

DOCTORAL THESIS

Community forensic mental health teams a Northern Ireland perspective

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Award date:
2015

Awarding institution:
University of Roehampton

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**Community Forensic Mental Health Teams
A Northern Ireland Perspective**

by

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A thesis submitted in partial fulfilment for the requirements of

the degree of

PsychD Forensic Psychology

Department of Psychology

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2014

ABSTRACT

This is a study investigating, from the perspective of service users, the most effective treatment interventions for mentally-disordered offenders overseen by a community forensic mental health service (CFMHTs) in Northern Ireland. This study researches what works best with mentally-disordered offenders in the context of three psychological models in the field of offender rehabilitation, namely: McGuire's (1995) 'What Works', Ward's (2001) 'Good Lives', and Andrews and Bonta's (1994) 'Risk, Need, and Responsivity' model.

This study is unique in that the views of service users, that is, the patient, and the family of the patient, as well as professionals, were sought. Service user views were obtained through undertaking three separate studies involving qualitative and quantitative assessment. Study one involved focus groups with results evaluated by thematic analysis; study two involved administering questionnaires developed from the focus groups to evaluate specific themes, whilst study three followed up specific issues with semi-structured interviews, the data again analysed by thematic analysis.

In study one, service users identified ten key themes as important in the treatment and management of mentally-disordered offenders within the community. Study two explored the significance of the themes for the three service user groups. There were a number of significant differences between groups identified in study two in the areas of risk management and public perception and awareness. The differences are reflective of elements of the 'Good Lives' model, such as the importance of the

therapeutic relationship. Study three undertook a more in-depth analysis of the questionnaire results, and endorsed the findings from studies one and two.

Throughout the three studies the ten themes reinforced the importance of the 'what works' literature from the perspective of service users. The one theory, however, which services users appeared to endorse most strongly, is Tony Ward's 'Good Lives' model and this is important for the future work of CFMHTs. The value placed by patients and families on the therapeutic relationship is one of the most significant findings to emerge from this research study and is reflective of the academic literature.

The findings of each study have been discussed in relation to existing research in what works with mentally-disordered offenders. Recommendations for improvement in the treatment of this group are identified. The more important of these include: involving the patient's family in their treatment and risk management; ensuring that a 'step-down' approach is adopted when patients move from security to community living; working to reduce stigma and Northern Irish cultural issues that adversely impact a patient's rehabilitation, and the importance of a positive therapeutic relationship between professional, patient, and families.

The research was limited by sample size and difficulty securing questionnaire responses from some professionals on time. Future research could increase the sample size by expanding numbers at a local level to other forensic teams in Northern Ireland. Furthermore, exploring re-offending data from the sample on a longitudinal basis would be informative.

Overall, this study highlights the centrality of service users in determining what works best in the treatment and risk management of mentally-disordered offenders.

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ACKNOWLEDGEMENTS

First and foremost I would like to thank my supervisors, Professor Robert Edelmann, Dr Marcia Worrell, and Dr Dianne Bray for their advice, expertise and continued support in the undertaking of my doctorate. I would like to extend particular thanks to Professor Edelmann whose advice, help, and encouragement has been invaluable.

I owe a great deal of gratitude to my husband, sons, parents, and brother who have supported me throughout this entire process. A special word of thanks goes to my father who has been my number one champion in the undertaking of this doctorate. I simply cannot put into words the degree of support and encouragement he has given me during my doctoral process.

I would like to dedicate this thesis to my sons Jacob and Ezra. To remind them that it is possible to achieve your dreams and to accept that even the most difficult person can change.

Finally, I would like to thank the participants who volunteered their time for this research. Without them this doctorate would not have been possible. For those reading this thesis I trust it illustrates that even the worst offender has the right to hope, for with hope a person can change.

CHAPTER 1

INTRODUCTION

1.1 Background

The main objective of the research is to examine and identify whether treatment interventions delivered for mentally-disordered offenders by a community forensic mental health team in Northern Ireland adhere to empirically-based rehabilitative models. This will be explored from the perspective of the offender/patient, the family of the offender/patient, and the professional currently receiving a service from this team.

The aims of the research study include:

- An examination of treatment interventions that are empirically based and 'work' best with mentally-disordered offenders in the community;
- How satisfied offenders and families are with the community forensic service and the value they place on same;
- An exploration of the therapeutic alliance between therapist and offender, and the significance of this in the current service provided
- An exploration of the legacy of the troubles in Northern Ireland and the potential negative impact of same on the treatment and rehabilitation of offenders and their families.

The research was motivated by my work as a Consultant Forensic Psychologist within a Community Forensic Mental Health Team (CFMHT) in a Health and Social Care Trust in Northern Ireland. Through working in this team, with professionals, patients, and families of patients, I felt there

was a need to practically review how effectively the team were applying psychological and academic models relating to offending behaviour. In particular, the factors or variables that influence positive mental health, pro-social relationships/lifestyle, and reduction in offending for the mentally-disordered offender (patient) living in the community. I was also keen to establish if the culture of an organisation and the relationship between patients, families of patients, and professionals impacts on the recovery of the patient.

In addition, in my professional role as a Consultant Forensic Psychologist I was mindful of the need for the profession to be always alert to opportunities where research-based evidence to develop policy and working practices can be garnered. Also, as part of the continuous development of my professional role I was anxious to improve my level of knowledge and insight into new ways of improving services to users. My professional role impacted on I how approached the research in several ways, including:

1. The concentration of the research on what works best as treatment interventions for mental health offenders and whether what is delivered is empirically based. In my role, I was professionally aware of the need to make improvements in services; the question was how to do so.
2. The opportunity to focus on the service users and providers as participants in the research. The service users knew me professionally and I had a good professional rapport with them, which gave me a good starting point for the research.

3. Enabling me to use the participants as a rich source of data collection in focus groups, surveys, and interviews.
4. The professional skills and experience of working with groups and individuals. I was able to recognise the pitfalls of bias, the management of group dynamics, observation, the importance of a cognitive approach (thoughts, perceptions, values, beliefs, expectations, etc.), and relating the research to the real world.
5. An understanding of psychological theories such as social learning theory, labelling theory, rehabilitative models, and the need for verifiable evidence-based findings.
6. Highlighting the point that the scientist-practitioner approach of the research required critical awareness, reflective practice, and adherence to ethical and professional standards as defined by the BPS.

These professional attributes were essential to the design and completion of the research. However, there were knowledge and practitioner aspects of the research process in relation to design, methodology, data collection, analysis, and evaluation that added to the professional experience and would positively impact on the Consultant Forensic Psychologist role. These included:

1. A high level of knowledge of qualitative and quantitative research methods, including appropriate question formulation and theoretical perspectives.

2. Data collection methods and analysis (including SPSS) and critical appraisal.
3. Methods to perform complex data analyses, interpretation, evaluation, and synthesis and improved competence in analysing quantitative and qualitative data.
4. New insights in the theory and practice of forensic psychology.
5. A better appreciation that the views of service users (participants) can revise the professional understanding of an area of inquiry.

The completed research has impacted on my professional work and the context in which I deliver services. This is referred to in the final chapter of the thesis, where the limitations of the research study are discussed.

The research is based on interventions provided by a local Community Forensic Mental Health Team. There has been some research in the UK looking at the effectiveness of different types of CFMHTs; Coffey (2006), Cohen and Eastman (1997), Godin and Davies (2005), and Mohan and Fay (2005) to name a few. However, as to date no research has evaluated the effectiveness of Community Forensic Mental Health Teams in Northern Ireland; this research study is the first of its kind to be undertaken in this setting. The work of the Community Forensic Mental Health Team from inception to December 2012 will be the timeframe for the research.

Mentally-disordered offenders generate much media and public interest. Therefore, research that investigates what is effective and 'works' with this population is of paramount importance. From a human rights perspective it is also vital that feedback from this client group is obtained. Traditionally,

offenders are a marginalised group and although they are offered a range of different services and treatment options they are often not asked how they feel about this service and especially whether they are satisfied with it. Approaches that assess both the patient and their family's perception of the service, and what treatment interventions mean for them are limited. This research will fill that gap.

The research will explore a number of offender rehabilitative models from the arena of forensic psychology and their effectiveness with the population of mentally-disordered offenders. Several theories will be examined, most importantly: 'What Works' (McGuire, 1995), 'Good Lives' (Ward, 2002), and 'Risk–Need-Responsivity' (Andrews and Bonta, 1995). At present there is an absence of research on what constitutes effective treatment for mentally-disordered offenders in the community. Furthermore, little attention has been paid to how to implement these theories and the challenges that might be experienced in doing so. To ensure that mentally-disordered offenders are risk-managed and treated effectively and from an evidence-based viewpoint, it is essential that the correct psychological models are applied. What is unique about this research study is that the perspectives of the patient, their family/carer, and the professional treating the patient will be sought. Differences in the three service-user group's perspectives will be compared across the three studies of the research.

An important objective will be to provide new knowledge to the offender-rehabilitation field. It will also be user-friendly and relevant to current practice, not only for community forensic mental health teams, but also the professionals, patients/families, and organisations who work with them.

The rationale, aims, objectives, and hypothesis articulated in the subsequent sections will provide a logical framework and direction of travel for the research.

1.2 Context for the Research

1.2.1 Northern Ireland Health and Social Care Services

The overall responsibility for the health and wellbeing of the population of Northern Ireland rests with the Department of Health, Social Services and Public Safety (DHSSPS), which is one of 11 Northern Ireland Departments created in 1999 as part of the Northern Ireland Executive by the Northern Ireland Act 1998, and the Departments (Northern Ireland) Order 1999. The Department has a statutory responsibility to promote an integrated system of Health and Social Care (HSC) which it states is designed to secure improvement in:

- *“the physical and mental health of people in Northern Ireland;*
- *the prevention, diagnosis and treatment of illness; and*
- *the social wellbeing of the people in Northern Ireland”*

The Department lists its three main business responsibilities as:

“Health and Social Care (HSC), which includes policy and legislation for hospitals, family practitioner services and community health and personal social services;

Public Health, which covers policy, legislation and administrative action to promote and protect the health and wellbeing of the population; and

Public Safety, which covers policy and legislation for fire and rescue services.”

In this legislative and policy environment, the Department has developed a departmental business plan for 2011-15 setting out the strategic priorities identified by the Minister, which contributes to the NI Executive’s wider Programme for Government. These strategic priorities are:

- *“To improve and protect health and wellbeing and reduce inequalities, through a focus on prevention, health promotion and earlier intervention;*
- *To improve the quality of services and outcomes for patients, clients and carers;*
- *To develop more innovative, accessible and responsive services, promoting choice and by making more services available in the community;*
- *To improve productivity, by ensuring effective and efficient allocation and utilisation of all available resources in line with priorities;*
- *To improve the design, delivery and evaluation of health and social care services through involvement of individuals, communities and the independent sector;*
- *To ensure that the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services.”*

The Business Plan states that “the principal service objectives for health and social care arm’s length bodies derive from these strategic priorities and

are set out in detail in the Health and Social Care Commissioning Plan Direction 2012.” The development of the Commissioning Plan is the responsibility of the Health and Social Care Board (HSCB) which was established by the Department and is accountable to it and the Minister. Its role is broadly contained in three functions:

- *“To arrange or ‘commission’ a comprehensive range of modern and effective health and social services for the 1.7 million people who live in Northern Ireland;*
- *To work with the health and social care trusts that directly provide services to people to ensure that these meet their needs;*
- *To deploy and manage its annual funding from the Northern Ireland Executive – currently £4 billion – to ensure that all services are safe and sustainable.”*

The Commissioning Plan importantly takes account of the recommendations of the Bamford Review of Mental Health and Learning Disability (Northern Ireland) that was undertaken in 2006 and established a number of key principles and recommendations as to how community forensic mental health teams in Northern Ireland should operate. This review is highly pertinent to the research and will be considered in detail in the Literature Review chapter.

Section 7.11 of the Commissioning Plan (2012/13) sets out the services to be commissioned for Mental Health and Learning Disability, including Forensic Services, Specialist Community Services and Community Learning Disability Teams, which are relevant to this research. Within this

commissioning framework, and under the overall supervision of the Department, a number of service delivery bodies operate. In the case of this thesis, this is primarily the Southern Health and Social Care Trust (SHSCT).

1.2.2 Southern Health and Social Care Trust (SHSCT)

The Southern Health and Social Care Trust was established in 2007 under the Review of Public Administration (RPA) and provides health and social care services across the five council areas of Armagh, Banbridge, Craigavon, Dungannon, and Newry and Mourne serving a population of approximately 335,000. The Trust employs approximately 13,000 staff and spends £532 million annually in the delivery of health and social care services in pursuit of its main objectives, which are to:

- *Provide safe, high quality care*
- *Maximise independence and choice for our patients and clients*
- *Support people and communities to live healthy lives and improve their health and wellbeing*
- *Be a great place to work*
- *Make the best use of resources*
- *Be a good social partner within our local communities.*

As part of its responsibilities in the delivery of the Commissioning Plan, the Trust provides a range of Support and Recovery Services which are 'recovery-orientated services provided to patients and clients with severe and enduring mental health needs.' This division of the Trust's service

includes the Recovery and Support Teams, incorporating the Community Forensic Mental Health Team (CFMHT).

1.2.3 Community Forensic Mental Health Team (CFMHT)

Introduction

The CFMHT, located within the Support and Recovery Services division of the SHSCT, includes staff from forensic psychology, psychology, psychiatry, and social work disciplines with the necessary competencies, skills, and experience to meet the needs of users and carers. The CFMHT fulfils the Bamford Review recommendation with the development of this specific service model and structure. Working with interconnecting services, such as probation, police, and prison services has been established. The need of the patient is the overriding focus and productive engagement to secure and deliver the 'best fit' patient treatment is crucial to success. Establishing and maintaining positive relationships with patient families in support of delivering good-quality outcomes is a top priority.

Emergence of Community Forensic Mental Health Teams in the UK

Community forensic mental health teams have become increasingly necessary over the past decade due to the increasing number of patients being admitted to, and discharged from, secure services. In England and Wales, during the early 1990s there were large rises in the number of patients being admitted to secure hospitals from the courts following criminal convictions (Judge and Fahy 2004). Furthermore, high profile homicides involving psychiatric patients accentuated the need for

community forensic mental health services and the management of violence in the community.

In 1992, 'The Reed Report' (Dr John Reed) provided a framework for the management of mentally-disordered offenders. The report acknowledged that mentally-disordered offenders have widely differing needs. It argued that multi-disciplinary planning and resourcing of mental health and learning disability services must take proper account of the needs of offender patients, and should be diverted from the criminal justice system at the earliest opportunity. The Reed Framework specifically addressed the management of offenders in the community and proposed a number of care values and principles that CFMHTs should uphold.

Mentally-disordered offenders should be cared for:

- With regard to quality of care and proper attention to the needs of individuals;
- As far as possible in the community rather than in institutional settings;
- Under conditions of no greater security than is justified by the degree of danger they present to themselves or others;
- In such a way as to maximise rehabilitation and their chances of sustaining an independent life;
- As near as possible to their own homes or families if they have them.

The Reed Principles emphasise that a balance must exist between individual rights, the need for treatment, and public safety. Lamb, Weinberger and Gross (1999) stated that both society and the criminal

justice system expect that treatment will be conducted under conditions that can, to the greatest extent possible, ensure public safety. The challenge therefore is not only in safeguarding the community, but also working with individuals who may resist treatment, for example by not keeping appointments, being non-compliant with medication, and refusing appropriate housing placements.

The creation of multiagency working through public protection panels led by police and probation (MAPPPs - Multiagency Public Protection Panels, England and Wales; and, PPANI - Public Protection Panels Northern Ireland) who monitor the progress of high risk offenders in the community also created a demand for input from health services.

Organisational changes in in-patient and community mental health services, expansion in forensic medium-secure facilities, and changes in societal attitudes have also driven the requirement for community forensic mental health services.

‘What Works’ Research

In 1995, McGuire developed a theory known as ‘What Works’. This theory provided a framework for rehabilitative programmes for offenders and advocated a number of principles regarding how such programmes should be delivered.

The UK Home Office advocates that community reintegration is the most critical process for achieving long-term change in offenders. Work to help

them achieve a settled lifestyle, and become involved in pro-social relationships and activities may well reduce the risk of re-offending.

The '**Risk-Need-Responsivity**' model is perhaps the most influential model for the assessment and treatment of offenders (Blanchette and Brown, 2006; Ward, Mesler and Yates, 2007).

Essentially three principles from this model are proposed:

- ***Risk principle:*** Match the level of service to the offender's risk of re-offending;
- ***Need principle:*** Assess criminogenic needs and target them in treatment;
- ***Responsivity principle:*** Maximise the offender's ability to learn from a rehabilitative intervention by providing cognitive behavioural treatment and tailoring the intervention to the learning style, motivation, abilities, and strengths of the offender.

The model proposes that services that adhere to the 'Risk-Need-Responsivity' model are more effective when delivered in the community.

The '**Good Lives**' model is an example of a positive psychological approach to the treatment of offenders. It argues that in order for a person to lead a happy, fulfilling, and offence-free life a number of 'primary goods' need to be met. These include, for example; social life, mental health and emotional wellbeing, and physical health. The model proposes that interventions with offenders should not only focus on the criminogenic

needs but also the non-criminogenic needs. These models are further elaborated in chapter 2, Literature Review.

Within the Southern Trust community forensic team these principles are adhered to through risk assessments validated for mentally-disordered offenders, such as the HCR-20, RSVP, and RAMAS structured offender programmes in the community to target criminogenic need, and also input from specialist forensic practitioners, such as social workers, community psychiatric nurses, psychologists, and psychiatrists. This work provides an opportunity for offenders to practice newly developed skills by applying them to daily problems they may face – in employment, accommodation, finance, or other aspects of their lives.

Cohen and Eastman (2000) in their paper *'Needs assessment for mentally disordered patients: measurement of ability to benefit and outcome'* proposed that when assessing the effectiveness of services for psychiatric patients, including mentally-disordered offenders, outcomes should be measured from multiple perspectives (e.g. patients, carers, clinicians). They stated that when evaluating forensic mental health services 'what works' for mentally-disordered offenders must be addressed so that clinical and service protocols can be addressed.

What do community forensic mental health teams do?

Mohan and Fahy (2006) outlined the roles of a community forensic mental health team in their paper 'Is there a need for community forensic mental health service?'

They specified the following as important roles:

Forensic case management

In community forensic mental health teams, clinical staff are in a key working role. This is in accordance with the statutory obligations under the Care Programme Approach (Department of Health, 1990). Caseloads are generally lower than those of generic workers, allowing the case manager to work in an assertive manner, seeing patients frequently, emphasising continuing risk assessment, management, and communication with colleagues. Forensic case management is likely to be offered to those patients who are deemed to pose the highest risk of violence.

Assessments and Advice

CFMHTs provide expertise in risk assessment and advice on risk management. Most clinicians in CFMHTs are trained in specialist risk-assessment tools, such as the HCR-20 (Webster, Douglas, Eaves and Hart, 1997).

Liaison with criminal justice agencies

Members of CFMHTs may attend MAPPS meetings and maintain close links with criminal justice agencies. Community teams are also well placed to provide necessary knowledge and expertise regarding risk assessment and management.

Specialist psychological interventions

CFMHTs are well placed to offer offending-behaviour programmes aimed at reducing offending. These therapies may include anger management,

thinking skills, interventions for substance misuse, and cognitive behavioural therapy for psychosis.

Models of Community Forensic Mental Health Teams

Various models of community forensic services have evolved. The two main models in the UK are the integrated model and the parallel model.

Integrated Model

Integrated community forensic mental health teams have both specialists and generic staff working out of the same team base. In these teams the staff carry larger caseloads and forensic workers look after both forensic and non-forensic patients. The advantage of this model is improved communication between forensic and non-forensic clinical staff, which facilitates the transfer of patients between forensic and generic case managers and encourages the dissemination of specialist skills.

Parallel Model

In contrast, parallel specialist teams operate with low caseload sizes and have a separate referral system. Such teams may have a greater opportunity to practice and retain specialist skills. The disadvantages can be increased costs, greater bureaucracy in referring to, and discharging from, services, and lack of dissemination of skills to generic mental health workers.

Some limited research relating to the effectiveness of these respective teams has been undertaken. Coid, Hickey, and Yang (2007) compared the effectiveness of the forensic (parallel) and general adult psychiatric services

(integrated) in relation to clinical and offending outcomes. They found no evidence of superiority as measured by re-offending behaviour or re-hospitalisation for either service. The research recommended that if forensic specialist services are to develop a parallel model of 'after care' in the future they will need to develop new community-based interventions to reduce risk, which take account of the needs of high-risk patients. This research is of particular relevance to the current evaluation as the community forensic mental health team in the Southern Health and Social Care Trust is a parallel model.

As yet, little evaluation of services in the UK has taken place. Key questions need to be asked concerning the type of patients being worked with, interventions, treatments, and the extent of multiagency working, referral processes, and care pathways.

Research conducted by Judge and Fahy in 2004 highlighted variability in community forensic services across England and Wales. The research found that most community forensic mental health teams provide comprehensive risk assessment but not specialised therapies to reduce offending behaviours. The research concluded that service models needed to be evaluated in order to inform future service development. Mohan and Fahy (2006) stated that the development of specialist community forensic mental health teams creates a welcome opportunity for clinical services to deliver targeted risk assessment, risk management, and treatment programmes for mentally-disordered offenders in the community.

Community Forensic Mental Health Teams (CFMHTs) in Northern Ireland

Until 2003-2004 Community Forensic Services in Northern Ireland were very limited. In 2004 funding was allocated to each of the 4 Health and Social Care Trusts (in 2008 these were changed into 5 Health and Social Care Trusts as part of a Review of Public Administration in Northern Ireland). In 2004 it was recommended that the CFMHTs ('CFTs') would work in a 4 level model:

1. Level 1: a one-off assessment/consultation with the CFT;
2. Level 2: a short period of assessment by the CFT with the referring team retaining responsibility;
3. Level 3: agreed period of shared responsibility – (a) to assess risk, (b) to evaluate interplay/operation of known risk factors, and (c) to assess efficacy of risk reducing strategies;
4. Level 4: CFT taking full responsibility for duration of need.

It was assumed that the majority of CFT's work would be at level 1 with only a small minority at level 4.

The Bamford Review (2005) made a number of recommendations as to how CFTs in Northern Ireland should operate. This current investigation will evaluate how effectively these recommendations have been implemented by the Southern Health and Social Care Trust CFT.

The recommendations include:

1. **A Co-ordinated Joint strategic Approach:** It was proposed by The Bamford Review that CFTs should be developed in a planned strategic manner by partnerships composed of service users and carers, commissioners and providers of services, representatives from forensic and interconnecting mental health services and from criminal justice agencies in both the statutory and independent sectors, and also representatives from the wider community. It was suggested that a regional forensic network should be established to coordinate the planning and development of community forensic services.
2. **Evidence, Principles, and Purposes:** The five CFMHTs should receive funding and workforce planning from the DHSSPS to ensure they are developed to full operational capacity by 2010. Thereafter, teams should be developed in response to need to ensure that they have full capacity to fulfil the range of services required by the service commissioners. It was recommended that commissioners should commission a full range of services incorporating the following:
 - Working jointly with other mental health and learning disability services to provide consultation, assessment, and support and in some cases, shared and sole treatment of care;
 - Liaison with police stations and courts;
 - In-reach to prisons and support of discharged prisoners with a mental disorder;
 - Assessing local referrals to secure inpatient services;

- Supporting the discharge of service users from inpatient services to the community, facilitating self-management, opportunities for employment and engagement in social activities;
- Assessments at the request of probation;
- Input to offender therapy programmes, and supporting the work of the Multiagency Procedures for the Assessment and Management of Sex Offenders and its successor PPANI (Public Protection Arrangements for Northern Ireland).

3. **Organisational Structures and Interconnections:** Community Forensic Services should develop specific service models and structures, and agreed methods of working with interconnecting services. The team should be composed of a range of staff with the necessary skills to meet the needs of users and carers.
4. **Comprehensive and accessible services:** A regional forensic network should be established to co-ordinate the development and delivery of forensic services, including the development of policies, procedures, and protocols.
5. **Risk Assessment and Management:** Community forensic services should develop risk assessment and risk management policies, procedures, and protocols that should draw upon best practice and coordinate with the arrangements of interconnecting services.
6. **Quality Assurance:** Community forensic services should have robust and demonstrable quality assurance mechanisms that involve service users and carers, and include setting standards and assessing the quality of services. There should be internal and external audit.

7. **Mental Health Promotion and education:** Community forensic services should contribute to wider programmes of mental health promotion and public education.
8. **Information, Research, and Innovation:** Community forensic services should develop information strategies that include contributing to evidence-gathering, research and innovation. Information Technology should be used where appropriate to enhance service quality and delivery.
9. **Recruitment, Retention, and Developing a Skilled Workforce:** the DHSSPS must ensure that development and maintenance of community forensic services is supported by robust workforce planning and provision of opportunities for staff to avail of learning, development, and support.
10. **Sustainable and Transparent Funding:** the development of community forensic services requires sustainable funding from the relevant sources. Funding arrangements must support the joint coordinated planning and delivery of services.

To date no research has been conducted to evaluate the effectiveness of CFTs in Northern Ireland. This investigation will consider whether the Southern Health and Social Care Trust have met the recommendations as outlined above in The Bamford Review.

Northern Ireland – Special Factors Impacting on the Research

Over a period of approximately 30 years the population of Northern Ireland experienced inter-communal division and conflict, often referred to as ‘The

Troubles'. This was mostly manifested in religious sectarianism, strident expression of separate cultural identities and different national allegiances. Most of the population was affected, either directly and/or indirectly. This very difficult situation improved through a developing 'peace process' and eventually resulted in successful inter-party negotiations, which produced the 'Belfast Agreement' in 1998. The Belfast Agreement provided special governance arrangements with new institutions incorporating political power sharing. This included a range of cross community 'checks and balances', the development of the strongest equality legislation in the EU, radical reform of policing, and other important changes to public bodies. Whilst there have been significant improvements in the lives of the population there are residues of community division in particular geographical areas and parts of society. An unfortunate legacy of 'The Troubles' is often a lack of trust across the protestant /catholic divide and suspicion of the authority exercised by some public bodies as well as the services delivered. The current research will evaluate the potential impact this challenging environment may have on services delivered by CFMHT.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This review examines current knowledge and research relating to treatment and rehabilitative interventions with mentally-disordered offenders. Interventions and psychological approaches adopted with this client group will be addressed, in particular, what is effective and ‘works’ in terms of reducing offending and improving mental health. Research on the attitudes and perceptions of the client group, family, and professional towards treatment will also be explored. Potential comparisons identified and differences between the three groups will be highlighted. Limitations in the research findings will be discussed.

2.2 Rationale for the Proposed Research

As outlined previously in chapter 1 the aims of the research study include:

- An examination of treatment interventions that are empirically based and ‘work’ best with mentally-disordered offenders in the community;
- How satisfied offenders and families are with the community forensic service and the value they place on it;
- An exploration of the therapeutic alliance between therapist and offender, and the significance of this in the current service provided;
- An exploration of the legacy of the ‘Troubles’ in Northern Ireland and the potential negative impact of them on the treatment and rehabilitation of offenders and their families.

The research investigates what is effective and ‘works’ best with a mentally-disordered population. What is unique about this research is that the views of service users will be sought regarding what works best for them, and whether they are satisfied with the service provision provided.

2.3 Focus of the Proposed Research

The proposed research will explore a number of offender rehabilitative models from the field of forensic psychology and their effectiveness with the population of mentally-disordered offenders. The theories to be examined include: ‘What Works’ (McGuire, 1995), the ‘Good Lives’ model (Ward, 2002), and ‘Risk-Need-Responsivity’ (Andrews and Bonta, 1994).

There has been little exploration as to whether CFMHTs in general follow recommendations from evidence-based research. The research will establish if this is the case and will explore the opinion of service users in this regard.

The literature review will outline the following:

- The mentally-disordered offender population;
- Rehabilitative theories/models to include: ‘What Works’ (McGuire, 1995), ‘Good Lives’ (Ward, 2002) ‘Risk-Need-Responsivity’ (Andrews and Bonta, 1994);
- Hospital and community-based treatment for mentally-disordered offenders;

- Local policy recommendations for CFMHTs, such as The Bamford Review, 2006;
- Involving service users in research, in particular the offender population;
- Client/patient satisfaction with treatment;
- Patient/therapist relationship.

There are a number of hypotheses to be tested through the proposed research; these are set out in section nine.

2.4 Mentally-Disordered Offender Population

2.4.1 Definition of Population

Mentally-disordered offenders are ‘persons who present both mental disorders and a history of criminal offending and/or repetitive aggressive behaviour towards others’ (Hodgin, and Muller-Isberner, 2000 pp7-38). The term ‘mentally-disordered offender’ has been used to refer to many different types of offenders (learning disability, psychopathy, and a variety of other mental disorders). Mentally-disordered offenders are a heterogeneous group usually with a long history of difficulties, multiple problems, and poor life and social skills. There are important differences between and within diagnostic groups relevant to treatment. The subject population for the current research is treated within a CFMHT and is a heterogeneous client group. Because of this, treatment has included multiple components which target different problems. There is, therefore, a need to evaluate both the

effectiveness of treatment provided with this population as well as the effect of individual differences and diagnostic groups on outcome.

2.4.2 Treatment of Mentally-Disordered Offenders

According to Harris and Rice (1997) there are three key areas of study that provide an empirical basis for the treatment of mentally-disordered offenders:

1) Treatment such as medication for people with major mental disorders is effective in reducing symptoms and increasing level of psychosocial functioning

Appropriate medication, taken on a long-term basis, is one of the essential components of treatment for people suffering from a mental disorder. However, medication improves only one aspect of the problem presented by mentally-disordered offenders. Many are non-compliant and have poor motivation, often requiring long-term hospitalisation. Life, social skills training, and psycho education involving areas, such as basic life skills, hygiene, diet, education of medication, vocational training, and input with patients' families all produce positive outcomes (Harris and Rice, 1997). This will be tested in the proposed research study.

2) Rehabilitative programmes shown to effectively reduce recidivism among mentally-disordered offenders

The results of several meta analyses are consistent in identifying reduction in offending from rehabilitative programmes. Andrews, Zinger, Hoge, Bonta, Gendreau, and Cullens' (1990) research indicates that psychologically-

appropriate treatment, as compared to control conditions, leads to a reduction of up to 50% in recidivisms. It affirms the value of psychologically-based treatment programmes for offenders, however, there still remains 50% who continue to offend. Therefore, although psychologically-based programmes are effective in reducing offending there is still a gap that needs to be addressed.

Wilson (2007) reported that there is a growing body of evidence that demonstrates the effectiveness and utility of psychosocially-based interventions in managing the problems of people with schizophrenia. Rice and Harris (1997) suggested that the treatment of mentally-disordered offenders should target aggression, life skills, substance misuse, active psychotic symptoms, and social withdrawal. Therefore, if predictors of recidivism are largely similar across different groups this means that treatment programmes that focus on offending behaviour can also be implemented with mentally-disordered offenders.

The Sainsbury Centre (2000) carried out a review of offending behaviour programmes and looked at whether they can be used with offenders who have a severe and enduring mental illness. Their review provided mixed results. Some of the programmes demonstrated an effectiveness of only 10% or less in terms of reducing offending rates. Others demonstrated an effectiveness of 24% in terms of reducing offending rates. Effectiveness was dependent on the type of programme, the age and gender of the offender, and the level of re-offending risk. The variables of age, gender, and risk of re-offending require testing to identify their significance and

importance in the reduction of offending behaviour. The current research study will explore this.

One of the key recommendations from this study was that the focus of offending behaviour programmes should not just be on changing the offending behaviour, but should also address the offender's wider circumstances such as employment, relationships, and housing (which are critical in helping offenders find pro-social goals and alternate ways of living). Recent research refers to this as the 'Good Lives' model. This will be discussed further, as it is an approach adopted by the CFMHT in the Southern Trust area where the participants in the current research are located.

Recommendations from the Sainsbury Centre (2000) research included:

- All offending behaviour programme facilitators should be trained to work with people who have the full range and complexity of mental health problems;
- Adaptations to make offending behaviour programmes more accessible to those with mental health problems should be of a practical nature, for example, making sessions shorter or providing support outside the group;
- The environment in which offending behaviour programmes are held should be supportive to allow participants the opportunity to practise skills. This requires the involvement and understanding of all staff.

While all the recommendations outlined by the Sainsbury review have been adopted, no research has been conducted to determine their effectiveness in terms of mental health and reduced offending. The current research study is based on an offending behaviour programme delivered to all mentally-ill offenders within a particular community, the Southern Health and Social Care Trust in Northern Ireland.

3) Specialised forensic community treatment programmes

There have been a small number of evaluations of specialised community programmes for mentally-disordered offenders outside the UK. Unfortunately the results are not necessarily transferable to the UK due to the influence of different cultures and legal variances in the management and treatment of mentally-disordered offenders (Pereira, Sarsam, Bhui, and Paton, 2005; Salize and Dressing, 2007). This reinforces the need for more UK-based research, as well as the value of the current research study. Harris and Rice (1997) indicate that forensic community treatment programmes share a number of common features. Firstly, compulsory participation with a community forensic service as ordered by the court or a tribunal; secondly, recognition by professionals in the CFMHT that they have a dual role in treating the mental disorder and preventing a further offence; thirdly, legal powers for mental health professionals to rapidly re-hospitalise patients against their will if they think that they will re-offend/behave violently; finally, structure, intensity, and diversity to address multiple problems presented by the mentally-disordered offender, and staff responsibility for ensuring compliance with the programmes. This research provides an important framework for working with mentally-disordered

offenders, however it has limitations in providing an in-depth analysis of what works best with this population in the community.

2.4.3 Relationship between violence and mental illness

According to the Sainsbury Centre for Mental Health (2000) it is estimated that nine out of every ten prisoners have some form of mental health problem. Furthermore, research from the Prison Reform Trust (2007) estimated that about 20% of male and 15% of female prisoners have previously experienced a psychiatric acute admission to hospital.

Less is known about offenders with mental health problems in the community, but studies have indicated that mental illness amongst this population is also very high. Solomon and Rutherford (2007) argue that the level of emotional needs that may have been directly related to the criminal behaviour of those serving community sentences was around 43%.

The link between violence and mental illness has been well researched and documented. There are commonalities among non-mentally-disordered offenders and mentally-disordered offenders. Bonta, Law, and Hanson (1998) conducted a meta analysis of studies predicting recidivism in mentally-disordered offenders and found that broadly similar factors predicted reoffending in mentally-disordered offenders as well as non-mentally-disordered offenders. Examples of these factors are: early onset of offending, educational problems, lack of employment, problems with ability to manage self, and own personal resources.

Grossman, Haywood, Cavanagh, Davin, and Lewis (1995) identified particular symptoms such as paranoia, delusions involving specific targets, and substance abuse as being associated with violent behaviour amongst mentally-disordered offenders.

2.4.4 Limitations of Research and Summary

Unfortunately, there is no strong empirical base as of yet for the treatment of mentally-disordered offenders in the community. Treatment programmes for non-mentally-disordered offenders have been shown to be effective, and the research indicates commonalities among non-mentally-disordered offenders and mentally-disordered offenders. However, there are limitations in the research as to what particular treatment works with this population and how the treatment should be delivered. What works, and how it works, are two key factors that will be taken forward in this research study.

2.5 Community and Hospital Treatment Approaches for Mentally-disordered Offenders

2.5.1 Introduction

As alluded to in chapter 1, the number and need for CFMHTs has become more important over the past decade as evidenced by a large rise in the number of patients being admitted to (and discharged) from secure hospitals following criminal convictions from the courts in England and Wales (Judge and Fahy, 2004). High-profile homicides involving psychiatric patients emphasised the need for community forensic mental health services and the management of violence in the community. The treatment

of mentally-disordered offenders has traditionally been a function of secure hospitals; however, an increasing number of this patient group are being treated in community settings, justifying the need for a longer-term programme of community care.

2.5.2 Management of Mentally-Disordered Offenders in the Community

In 1992, The Reed Report provided a framework for the management of mentally-disordered offenders (see chapter 1 pages 18-19). The report acknowledged that mentally-disordered offenders have widely differing needs. The Reed Framework specifically addressed the management of offenders in the community and proposed a number of core values and principles that CFMHTs should uphold (see chapter 1 pages 18-19).

The Reed Principles emphasise that a balance must exist between individual rights, the need for treatment, and public safety. The challenge therefore is not only ensuring safety for the community but also working with individuals who may resist treatment through not keeping appointments, being non-compliant with medication, and refusing appropriate housing placements.

Important contributory factors in the need for developing community forensic mental health services have been organisational changes in in-patient and community mental health services, expansion in forensic-medium secure facilities, and changes in societal attitudes. CFMHTs were established to help manage offenders in the community and address a range of problems, including both criminogenic needs and non-criminogenic needs. As the

evidence reveals that offenders have multiple criminogenic needs it is suggested that a multi-modal approach to interventions is expected to be the most effective way of dealing with offenders (McGuire 2002). In accord with this research, CFMHTs adopt a multi-modal approach to their interventions with offenders.

Heilbrun and Griffin (1998) reviewed community-based treatment programmes for mentally-disordered offenders. They concluded that there is little empirical research provided in the literature about the impact of specific programmes or particular interventions in reducing the risk of future non-violent crime or violent behaviour. However, they do summarise a number of empirically-supported considerations in implementing community-based programmes for mentally-disordered offenders.

1. The programme must prioritise the prevention of violence amongst its most important goals, and this should be communicated to staff, clients and others;
2. There should be delivery of a range of services, including financial support, housing, and vocational support;
3. There should be skill-based training and treatment interventions;
4. There should be a focus on rehabilitating and preventing substance abuse;
5. There should be individualised assessment of need and risk using well-validated tools. For example HCR-20 (Webster et al 1997) for assessment of the risk of violence;

6. High-risk clients should receive more intensive treatment, based on Andrews and Bonta's (1995) 'Risk, Need Responsivity' theory;
7. There should be a balance between individual rights, the need for treatment, and public safety;
8. There should be good communication between criminal justice agencies and the mental health service;
9. There should be an understanding of the legal requirements and intensive case management.

The current research will determine, through review of the academic literature and consultation with service users, what risk factors are relevant for mentally-disordered offenders and therefore contribute to a reduction in risk of re-offending. Unfortunately, there is a lack of research on the impact of supervision of mentally-disordered offenders in the community. The current research will help develop this under-researched area and the results will help to improve the intensity and quality of the interventions that some mentally-disordered offenders receive.

2.5.3 Benefits of Community Forensic Mental Health Teams (CFMHTs)

Benefits outlined by Fiander and Burns (2000) of community forensic mental health teams include:

- Social reintegration of offenders into the community;
- Psycho-social interventions, such as individual and group therapy, which address the cognitive deficits associated with offending

behaviour will reduce risk of re-offending ('What Works' research McGuire, 1995);

- Overall reduced risk of re-offending;
- Assistance with practical needs such as housing, accommodation, and benefits. This links into Ward's 'Good Lives' model (2002), which advocates that addressing practical needs has a positive impact on the offender's risk;
- User and carer needs-led assessment;
- Joint working with community mental health teams;
- Liaison with outside agencies such as the police, probation, and public protection units.

2.5.4 Research undertaken with CFMHTs

There appears to be a lack of research undertaken concerning CFMHT and the work they provide. A review of the research indicates that it has largely focussed on comparing the different types of CFMHTs in operation, namely the parallel and integrated models. Parallel teams are characterized by having a separate referral meeting, a separate team base, specialist team managers, specialist supervision, specialist forensic psychology staff, small caseloads, protected budgets, more access to protected funding and training opportunities, good links with the criminal justice system, and separation from other community services. Integrated teams are characterized as having better access to community resources and services, being more likely to receive referrals from primary care, and having greater ease of transfer between services.

There is also a body of research that explores service users' experiences of forensic mental health services. Godin and Davies (2005) explored, with service users, their experiences of medium-secure forensic services. Through focus groups with service users they identified a number of negative feelings from service users. These included; mistrusting staff, feeling staff had been dishonest, stigma from receiving a forensic service, and generally not being able to move on with their lives because of involvement from a forensic service. The research seemed to focus only on negative feelings/experiences. This is a limitation of the study; both positive and negative experiences will be explored in the current research.

2.5.5 Limitations of the Research and Summary

A review of the literature highlights limited empirical research into what makes an effective community forensic mental health team, and more importantly the impact of the service on the mentally-disordered offender/patient. Most of the research on community forensic mental health teams appears to focus on the different models of teams. Although this is valuable information about how teams work, and it helps the service determine the model that will work for them, it does not provide any information on what works best for the patient. It is clear that further research is required in this area, in particular, the type of theories adopted and their application, and how effective these are for offender rehabilitation.

Furthermore, existing research has focussed on forensic mental health services in secure environments (Wilkinson 2008) but little on the impact of a community treatment service. The fundamental question is whether

findings from secure services can be transferred to forensic community settings. There is a need for research that informs clinicians as to what works and does not work well, and also explores the experience of service users receiving the treatment.

2.6 Rehabilitative Theories/Models

2.6.1 Introduction

This section reviews three theories/models of offender rehabilitation:

- 1. 'What Works' model (McGuire 1995);**
- 2. 'Risk-Need-Responsivity' model (Andrews and Bonta, 1994);**
- 3. 'Good Lives' model (Ward 2002).**

All of the above models have many components relevant to the current area of research. There are areas of limitation however, which the current research will acknowledge and address.

Research indicates that rehabilitation is more effective in reducing offending than punishment and prevention (e.g. Andrews and Bonta, 2003). However, effective offender rehabilitation needs to balance the rights of the community with the rights of the offender, whilst at the same time protecting the community. Traditionally Psychologists and Psychiatrists have led and developed programmes and risk assessments with offenders. Psychologists use the scientist-practitioner model, i.e. providing services based on theory. According to Birgden (2008 pp 450-468), 'a psychological theory and its principles guide offender assessment, treatment and management in practice. Assessment determines the function of the

offending and treatment determines the intervention that will result in behaviour change.'

The 'Risk-Need-Responsivity' and 'Good Lives' models are psychological theories that address offender rehabilitation and, in part, form the focus of the current research study.

2.6.2 'What Works' (McGuire et al., 1995)

What works, theory, practice and outcome

McGuire's (1995) 'What Works' is a significant theory in the field of Forensic Psychology and has provided a set of principles for best practice in the rehabilitation of offenders. This theory has provided a framework for rehabilitative programmes for offenders and advocates a number of principles as to how such programmes should be delivered. McGuire (2001) outlined these principles, concluding that programmes and services work best in reducing re-offending when they conform to the following:

- They are based on an explicit model of the causes of crime, drawn from empirically sound data;
- They have a risk classification – i.e. more intensive programmes should be targeted at high- and medium-risk offenders;
- They target criminogenic needs;
- They are responsive, so that offenders benefit from interventions, which are meaningful to them and delivered in a way that is appropriate to their learning styles;

- Offenders should be given the opportunity to practise new skills/attitudes and behaviour, and motivation should be addressed;
- The treatment method is skills-oriented, active, and designed to improve problem solving in social interaction, based on cognitive behavioural techniques;
- The programme's impact is substantially influenced by the manner and setting of delivery (i.e. quality of delivery and programme integrity).

In addition to this, Lowenkamp and Latessa (2002) proposed that effective treatment depends on:

- Organisation cultures being based on well-defined ethical principles and responding efficiently to issues that have an impact on treatment facilities;
- Programmes based on empirically-defined needs, which are consistent with organisational values;
- Professionally trained staff with experience of working in offender treatment programmes; and psychometric instruments of proven predictive validity to assess offender risk.

McGuire (2002) suggested that community-based programmes, in general, produce more positive results. The current research is designed to evaluate the effectiveness of a CFMHT in Northern Ireland. It is hypothesised that the current research will replicate McGuire's research findings that community programmes are more effective for offenders and, in particular, mentally-disordered offenders, thus adding to research in this area. Interventions using cognitive-behavioural techniques, which focus on the

thinking skills of offenders, also produce the greatest reduction in re-offending (for example, Hollin, 1999). Cognitive skills programmes are a specific type of cognitive-behavioural intervention, sometimes referred to as 'thinking skills' programmes. Such programmes seek to address 'thinking deficits' by teaching new ways of thinking mainly through skills practice. The CFMHT currently delivers such programmes for its offender population.

Efficacy with adult male prisoners

Friendship, Nugent, Cann, and Falshaw (2002 and 2003) conducted research on adult male prisoners who had participated in cognitive skills programmes between the period of 1992 and 1998. In relation to research undertaken between 1992 and 1996 they found significant differences in reconviction rates for prisoners who participated in programmes compared to those who did not with programme attendance reducing reconviction by up to ten percent. However, later research conducted between 1996 and 1998 found no difference in a sample of matched prisoners who participated, and did not participate, in such programmes. When this was further investigated it was found that during the latter period many of the 'What Works' principles had not been adhered to. The period of evaluation related to a time when there was rapid expansion of programme delivery within the prisons which may have compromised treatment quality. Furthermore, the distribution of risk level in programme participants differed between the two studies. In the latter study there was a higher proportion of low-risk offenders and a lower proportion of high-risk offenders. This goes against the 'What Works' principles of more intensive treatment being targeted at higher-risk offender groups. The differences between these two

studies highlight the importance of adhering to the principles of the 'What Works' theory in the field of offender rehabilitation.

'What Works' demonstrates the efficacy for psychological interventions with offenders. McGuire (2002) stated that structured programmes using 'What Works' principles can attain an average of 40% reduction in recidivism in community settings and 30% reduction in institutional settings. For example, by offering offending behaviour programmes based on cognitive behavioural theory to address the cognitive deficits associated with offending behaviours.

Until recently, much of the evidence base for 'What Works', particularly with sexual offenders, has been based on research undertaken in the United States and Canada, (Marshall, 1996). There are limitations to this research, as it cannot be assumed that the findings from the US and Canada can be generalised to the UK. There may be influences that are culturally specific to the UK and in particular Northern Ireland. For example, consideration needs to be given to the impact of the Northern Ireland 'Troubles' on mental health and the facilitation of offending behaviour. There is a need for more research on what works in reducing offending in the UK, and particularly in Northern Ireland where even less research on this subject has been conducted. The current research will therefore significantly contribute to the 'What Works' theory as it currently stands and provide additional insights into the rehabilitation of offenders in Northern Ireland.

Cater, Klein, and Day (1992) emphasised the importance of reconviction as a key indicator of performance within the English and Welsh Prison Service

and it remains the standard measure of re-offending. It is hypothesised that offenders involved in rehabilitative programmes, for example services delivered by CFMHT, are less likely to reoffend compared to those who are not.

There are a number of outcomes that will be considered in this study known as non-reconviction benefits, such as increased self-esteem, confidence, healthy physical life and improved social life. For example, short-term outcomes that can be used to supplement reconviction to assess the impact of interventions, thereby providing a better understanding of how interventions work (Friendship et al, 2003). These outcomes could be said to fall within the 'Good Lives' model, which is outlined in more detail below.

Efficacy with mentally-disordered offenders

Blackburn (2004) reviewed the findings for 'What Works' with mentally-disordered offenders. This is the group of offenders that the current research is concerned with. Blackburn found that traditionally the treatment and rehabilitation of mentally-disordered offenders has been in secure settings. Evidence for the effectiveness of psychological interventions has been scarce and has been limited to more short-term treatments. He found some evidence for effective use of direct community programmes that met the needs of public safety and re-integration of the individual. He also recommended more long term services and complex psychological contributions to meet the complex needs of mentally-disordered offenders.

The UK Home Office advocates that community reintegration is the most critical process for achieving long-term change in offenders. Work to help

them achieve a settled lifestyle, and become involved in pro-social relationships and activities, may well reduce the risk of re-offending.

Cohen and Eastman (2000) proposed that when assessing the effectiveness of services for psychiatric patients, including mentally-disordered offenders, outcome should be measured from multiple perspectives (e.g. patients, carers, clinicians). They stated that when evaluating forensic mental health services, 'What Works' for mentally-disordered offenders must be addressed so that clinical and service protocols can be addressed.

The current research will also include an evaluation of the opinions of professionals involved in accessing a community forensic mental health service. This will help ensure that multiple perspectives of the service are being included and reviewed.

Looking beyond 'What works'

Ferguson (2002) looked at 'What Works' from an organisational perspective. Specifically the research investigated the implementation of 'What Works' theory in Marcicopa County Adult Probation Department (MCAPD) in the US. In this research the point is made that, although the knowledge base of what constitutes effective services for offenders has grown, and organisations or services are implementing the 'What Works' principles, there is little practical guidance on how organisations can take this research and implement it in daily practice. Bonta (1997) identified three steps that should be followed to put research findings relating to assessment and treatment into practice:

1. There needs to be organisational commitment to the value of rehabilitation. In the current research study the opinion of the organisation by way of the professionals who refer into the service is sought. The commitment must include dedication of time and resources;
2. Valid instruments need to be used to accurately assess offender risk and needs;
3. Cognitive behavioural approaches should be used to improve the effectiveness of treatment.

However, as identified by Ferguson (2002), there is no discussion of the practical challenges that might be faced by services while trying to implement any of the above steps. Through conducting research on the MCAPD, Ferguson identified lessons learned when implementing 'What Works' theory. One of the major changes the MCAPD made was about the risk-assessment tools they used. They designed their own tool to inform decisions around the level of treatment services that should be received, and to ensure it would provide a broad and overall assessment of risk and the needs of the offender. In implementing this new tool called Offender Screening Tool (OST); a number of lessons were learned:

1. Was the investment of time and effort worth it? Through devising a new risk assessment tool that adhered to the 'What Works' principles the MCAPD wanted to conduct a more systematic assessment that would be meaningful to probation staff. Changes were noted that suggested the investment was worth the effort. Information was

gathered more systematically, and assessment became a routine part of the staff's job. The information gathered was also meaningful and allowed more time to be devoted to the high risk and high needs cases;

2. They also learnt how important the commitment of the organisation is, particularly the top levels of management, for implementation to be a success. For example, addressing resource issues, and providing a consistent message to staff about the need for change;
3. Once the commitment has been made, it is important that resources match the need to sustain the project or programme;
4. Good-quality training was necessary to sustain the project;
5. Acknowledging the concerns of staff as they adjust to change, providing them with opportunities to voice their concerns, and planning for ways to respond to these concerns;
6. Finally, being prepared to face challenges and anticipate what the challenges may be.

Ferguson's research outlines important considerations when putting the findings of research into practice. In the current research study the application of rehabilitative theories will be investigated from the perspective of different groups and the value service users place on the approach adopted.

Work undertaken by Maruna (2001) in the field of offender rehabilitation argues that research in this area needs to focus on how things work rather

than 'what works'. He proposes that more attention should be focussed on the process of change, and that treatment should focus rather less on trying to change offenders who have little intention of changing, and more on supporting those who have shown themselves to be motivated towards change and are capable of it. Maruna's research, which is outlined in his book – *Making Good: How Ex-Convicts Reform and Rebuild their Lives* (2001) – sought to understand how offenders see themselves and their offending rather than measuring them. He considers why people with a record of persistent offending cease committing crimes. Maruna interviewed 55 men and 10 women in the Liverpool area of England, of whom 30 were identified as being 'desisters' of crime. To qualify for this definition they had to have had a substantial history of offending extending over a period of years and not to have committed an offence for over a year. Finally, they had to have declared the intention of refraining from offending. This expressed intention was seen in the research study as being the key part of their reaction of themselves as ex-offenders. The 'desisters' were contrasted with 20 'persisters' (i.e. who were actively involved in crime and wanting to continue to offend). The field work involved 2-3 hour interviews, including a standardised personality questionnaire, a criminal behaviour checklist, and social background survey. The focus was allowing individuals to 'tell their story'.

Maruna's research argues that the existing explanations for ceasing to offend are not adequate. He states that what matters when offenders become rehabilitated is not so much a change in external factors, such as getting a job or going on an offending programme, but a change that takes

place within the person. 'Persisters' and 'desisters' had similar characteristics and backgrounds amongst repeat offenders but the 'persisters' were characterised by a fatalistic outlook in which they saw themselves as 'doomed to deviance', which Maruna called 'condemnation script'. The 'desisters' on the other hand acquired a 'redemption script'; essentially a good person who has realised their true 'inner potential'. Maruna goes on to say that what underpins the change is not clear, although it does seem that some outside force in the form of someone or some agency showing sufficient faith in the offender to help him or her effect a transformation is an important factor.

This research is of particular interest as it focuses more on the process of change rather than looking at what works within offender rehabilitation. It will be interesting to incorporate this into the current research study through focus groups and interviews with the offender population. Maruna also states that one of the biggest obstacles 'desisters' face is obtaining the acceptance that they are reformed characters from others in society. He argues, therefore, that there should be more opportunity for recognising and affirming redemption. Again, in the current research study one of the areas of exploration will be whether offenders face stigma in the community. This will be explored from both the offender's perspective and that of their family/carer.

2.7 'Risk-Need-Responsivity' (Andrews and Bonta, 1994)

The 'Risk-Need-Responsivity' theory was first developed in the 1980s. It became formalized in 1990 and since then has been used within the

offender rehabilitation field. Andrews (1995) stated that the factors that determine criminal conduct are not like those that determine all socially-valued human behaviour. Individual differences need to be taken into account when planning effective offender rehabilitation. The 'Risk-Need-Responsivity' theory is recognised throughout the world. It is recognised as a personality and cognitive social learning theory of criminal conduct (Andrews and Bonta, 2006).

Core Elements of 'Risk-Need-Responsivity' Theory

The theory has three core elements to it:

1. **Risk:** the theory advocates that the treatment of offenders should focus on those offenders assessed as highest risk. In other words, highest-risk offenders should receive more intensive interventions whilst lower-risk offenders should be offered lower intensity programmes, if any at all. Andrews and Bonta's research showed that mismatching risk and intensity led to increased offending;
2. **Need:** the theory stresses the importance of addressing criminogenic needs (i.e. offending needs) when, for example, designing offender treatment programmes. This was termed 'criminogenic needs'. The theory advocates that it is these factors that need to be targeted in order to reduce the risk of re-offending. So, for example, sexual offenders require treatment specific to sexual behaviour difficulties whilst alcoholics require substance abuse treatment;

3. **Responsivity:** this advocates that treatment should be responsive to the needs of the offender, and is delivered in a way that is meaningful and makes sense. For example, tailoring interventions to the learning style, motivation, abilities, and strengths of the offender. Treatment plans must be tailored to such issues in order to be of the most effect.

In the current research study the population in question is predominately composed of mentally-disordered offenders. As well as investigating whether community forensic mental health teams adhere to the three principles of risk, need, and responsivity, the study is particularly interested in how these principles 'fit' with the mentally-disordered offender population compared to the general offender population, i.e. those who do not have formal diagnosis of a mental illness. In this regard the responsivity principle will be particularly important. The literature makes specific reference to two parts of the responsivity principle, namely, general and specific.

General responsivity calls for the use of cognitive social learning methods to influence behaviour. It is said that cognitive social learning strategies are the most effective regardless of the type of offender whether psychopath, sex offender, or female offender. Core practices such as pro-social modelling, the appropriate use of reinforcement and disapproval and problem solving indicate specific skills represented in the cognitive social learning approach.

Specific responsivity is a 'fine tuning' of the cognitive behavioural intervention. It takes into account strengths, learning style, personality,

motivation, and bio-social (gender, race) characteristics of the offender. The 'Risk-Need-Responsivity' theory has greatly influenced the development of offender risk assessments and rehabilitative programmes. The present research study is interested to know if 'specifics' have been developed with regard to mentally-disordered offenders, and if so how well community forensic mental health teams are implementing these.

The research literature regarding the efficacy of the 'Risk-Need-Responsivity' model with regard to offender rehabilitation includes several meta-analyses. In addition to Andrews and Bonta's (2007) work, later research (Dowden and Andrews, 1999a, 1999b, 2000, 2003) showed clearly that sanctions alone are unlikely to reduce recidivism. Adherence to the 'Risk-Need-Responsivity' model in these studies has shown a reduction in reconviction rates. Further studies have looked at the applicability of 'Risk-Need-Responsivity' to different offender populations. Hanson (2006) demonstrated that the principles also apply to sexual offenders and was associated with reduced sexual recidivism. This provides evidence in the use of the 'Risk-Need-Responsivity' model, specifically amongst sexual offenders.

Application of 'Risk-Need-Responsivity' to different offender populations

DeMatteo, Hunt, Battastini, and La Duke (2010) reviewed the application of the 'Risk-Need-Responsivity' model to different offender populations:

1. **Sex Offenders:** There has been much debate over the years as to what works best with sex offenders, from the relapse prevention

approach (Laws, 1999), including in relation to cognitive behavioural therapy (Hanson, 2009). However, there is general agreement from research findings that the assessment and subsequent recommended interventions need to be tightly connected. This is consistent with the literature on the use of the 'Risk-Need-Responsivity' model in guiding the risk management of sex offenders (Hanson, Bourgon, Helmus, and Hodgson, 2009; Harkins and Beech, 2007).

Hanson et al. (2009) conducted a meta-analysis of 23 community and institutional correctional interventions for adult and juvenile sex offenders. Their results showed that programmes adhering to all three principles of the 'Risk-Need-Responsivity' model had the largest reductions in sexual and general recidivism compared to programmes that adhered to none of the principles. This supports the application of the 'Risk-Need-Responsivity' model to sex offender treatment programmes. DeMatteo et al. (2010) argue that further research is needed to investigate why these programmes do not adhere to the 'Risk-Need-Responsivity' principles.

In their review, DeMatteo et al. (2010) also consider the risk factors for sexual offending. They argue that accurate risk appraisal needs to attend to both static (unchanging and historical risk factors such as prior sexual offences, age and gender of victim) and dynamic risk factors (those risk factors that change such as attitudes towards sexual abuse, coping mechanisms, and social support). Targeting dynamic risk factors in sex offender programmes helps estimate an

offender's recidivism risk level. Doing so would adhere to the *needs* principle of the 'Risk-Need-Responsivity' model. Hanson et al. (2009) suggest that attention to the needs principle would have the greatest influence on facilitating a productive change in the interventions currently provided to sex offenders. They go on to suggest that treatment providers review their programmes to ensure that the treatment targets emphasize those factors empirically linked to recidivism;

2. **Juvenile Offenders:** DeMatteo et al. (2010) state that there are concerns with regard to how risk management plans are linked to recidivism amongst juvenile offenders. They suggest that many clinicians rely on their own subjective expertise to formulate decisions regarding risk and treatment plans. They go on to highlight that responsivity factors are not being used to tailor programme implantation and effectiveness, for example, learning style, cognitive ability, and psychological functioning, and that professionals focus on factors unrelated to re-offending such as increasing ambition for success. DeMatteo et al. (2010) argue that although these are important goals to have, overlooking criminogenic needs can 'negatively impact treatment selection, the applicability of the treatment to the individual, and the effectiveness of the treatment in reducing recidivism';

3. **Mentally Ill Offenders:** DeMatteo et al. (2010) argue that risk is an important consideration when working with mentally ill offenders. They state that some studies consider persons, for example, with a

diagnosis of schizophrenia, to be at high risk of recidivism, whilst others are placed into a low risk category (Mullen, 2000). Research has shown that programmes aimed at high-risk mentally ill offenders have shown success in reducing violence risk (Swanson, Swartz, Elobgen, Mustillo and Dorn, 2000).

Interestingly, DeMatteo et al. (2010) highlight the fact that different professional groups focus on the different needs of the mentally-ill offender. They suggest that psychiatrists tend to focus on pharmaceutical interventions, and psychologists on personal factors such as a client's insight into their offending behaviour. Occupational therapists focus on developing life skills, and social workers on post-discharge living arrangements. Evidence-based practices, like 'Risk-Need-Responsivity', emphasize that treatments should consider criminogenic needs, whereas focusing on factors such as the diagnosis of severe mental illness and the development of life coping skills show minimal reductions in recidivism (Andrews and Bonta, 2006).

It is argued that more research needs to be conducted comparing these traditional treatment modalities and evidence-based practices such as 'Risk-Need-Responsivity'. The current research study will go some way to review if this is the case with community forensic mental health teams. These teams include some of the above professionals. The current research will explore the use of evidence-based practices with the mentally-ill/disordered population;

4. **Female Offenders:** According to DeMatteo et al. (2010) there are offending programmes for females that target criminogenic needs that are relevant for female offenders. This would be consistent with the 'Risk-Need-Responsivity' principles of being responsive to the needs of the offender. However, there are concerns regarding the type of risk assessments used with female offenders, such as the Level of Service Inventory-Revised (LSI-R) (Andrews and Bonta, 1995), which, although it is designed to be gender neutral, may not be as robust a predictor of recidivism among female offenders (Van, Voorhis, Wright, Salisbury, and Bouman, 2010). It is suggested by Van et al. (2010) that adding female-specific risk factors may very well increase their validity for female offenders.

DeMatteo et al. (2010) conclude by saying that recent studies demonstrate that adherence to risk/needs models does reduce recidivism. However, they also argue that many interventions used with groups of offenders are not based on a thorough assessment of risk factors. Furthermore, in some instances, such as female offenders, the criminogenic needs of offenders are not being properly assessed. They conclude with two recommendations for those researching this area: (1) whether treatment programmes that target criminal offenders are adhering to the basic elements of the risk/needs assessment and intervention models, and (2) whether adherence to such models results in meaningful reductions in criminal recidivism among specific groups of offenders.

The current research aims to examine whether interventions for mentally-disordered offenders undertaken by a community forensic mental health

team is adhering to 'Risk-Need-Responsivity' and other rehabilitative models, and if so, what impact this has on the offender and their family/carer.

Critiques of 'Risk-Need-Responsivity' Model

There has been some criticism of the 'Risk-Need-Responsivity' model. The main argument is that its focus on criminogenic needs is a necessary, but not sufficient, condition for effective treatment (Ward and Gannon, 2006; Ward, Mesler, and Yates, 2007). It is argued that the 'Risk-Need-Responsivity' model does not fully address deficits such as poor motivation to engage in rehabilitation. It is further argued that treatment should go beyond the 'Risk-Need-Responsivity' approach if it is to be maximally effective (Ward et al., 2007), and furthermore that the 'Risk-Need-Responsivity's sole focus on risk reduction does not provide therapists with the skills and tools to engage offenders in therapy or to provide offenders with the motivation to engage.

A further criticism is that the 'Risk-Need-Responsivity' model has a tendency to over-categorize offenders into risk levels and subsequently treatment streams, without attending to individual needs. Ward et al. (2007) discuss the delivery of treatment interventions in correctional settings using the 'Risk-Need-Responsivity' approach. They argue that although these programmes may set out with the best of intentions, they 'often go by the wayside as administrative concerns and individual offender quirks are encountered'. Ward feels that some of the best 'Risk-Need-Responsivity' interventions are offered by non-correctional enterprises, and he names a

few of these such as Circles of Support and Accountability (COSA – Wilson, 2007; Wilson, McWhinnie, Picheca, Prinzo and Cortoni, 2005, 2007), a volunteer-driven approach to supporting high-risk sexual offenders that are released without formal supervision or treatment. What will be interesting about the current research is that it will review the CFMHT ‘Risk-Need-Responsivity’ approach and whether it attends to individual needs as well as addressing risk, need, and responsivity.

2.8 The ‘Good Lives’ Model

In the ‘Good Lives’ model an individual is hypothesized as committing criminal offences because they lack the capabilities to realize valued outcomes in personally fulfilling and socially acceptable ways. The ‘Good Lives’ model is an example of a positive psychological approach to the treatment of offenders, which aims to address some of the limitations outlined above with the ‘Risk-Need-Responsivity’ model. Positive psychology finds its roots in the humanistic psychology of the 20th century which focussed heavily on happiness and fulfilment. One of the areas of research within positive psychology is the study of the ‘Good Life’. It assumes that as human beings, offenders are goal-directed organisms that are predisposed to seek a number of primary goods. Primary goods are states of affairs, states of mind, personal characteristics, activities, or experiences that are sought for their own sake and are likely to increase psychological wellbeing if achieved. Extant psychological, biological, and anthropological research literature indicates that there are at least ten groups of primary human goods (Aspinwall and Staudinger, 2003). These are often grouped into three main categories: Physical Health, Mental

Health, and Social Life. One of the functions of a CFMHT is to support offenders in their recovery within the community, and this involves assessing the presence of 'Good Lives' in an offender's life. How stable is the offender's mental health? Does the offender require help with their mental health? Do they need advice in their relationships and accessing community services (Social Life)? How does their physical health impact on their mental wellbeing and social life? The 'Good Lives' theory provides a framework for working positively with CFMHTs in the community.

In the 'Good Lives' model, care is provided through rehabilitation with the offenders for the offenders; although on the surface this may appear to be a model that is working solely for the offender, when the model is explored further it clearly addresses offending. It works with the offender on targeting areas of their lives that have broken down and thus made offending more likely. The view is 'at the end of the day most offenders have more in common with us than not, and like the rest of humanity have needs to be loved, valued, to function competently, and to be part of a community' (Ward and Brown, 1998 p. 244).

'Good Lives' is 'a way of living' that is beneficial and fulfilling for individuals (Ward 2002 pp514-528). A '*good life*' for an offender is essentially a way of living that is realistic, that meets basic human needs, and takes account of the individual's interests, skills, temperament, abilities, and support networks. Ward advocates that a necessary condition for the reduction in offending is living a life that is more fulfilling and rewarding. Ward states that 'individuals are unlikely to refrain from offending if their lives are characterized by an absence of valued outcomes' (Ward 2002 pp514-528).

Offending for some individuals may be the only source of outcome and a way of achieving personal goods. The 'Good Lives' model argues that in order to rehabilitate offenders it is necessary to instil in them the skills, knowledge, and resources to live different kinds of lives.

What is a 'Good Life'?

Ward's 'Good Lives' model focuses on the concept of 'primary goods'. Essentially, primary goods are 'actions or states of affairs that are viewed as intrinsically beneficial to human beings and are therefore sought for their own sake rather than as a means to some more fundamental ends' (Ward, 2002 pp514-528). He goes to say that a good life can only become possible when 'an individual possesses the necessary conditions for achieving primary goods, has access to primary goods, and lives a life characterized by the instantiation of these goods' (Ward, 2002 pp514-528).

The ability to realise that primary goods are important for a healthy and fulfilling life is dependent on the capacity to plan and make decisions, and to implement plans. In other words, to put into action a plan for living that provides access to the primary goods by way of certain living arrangements, facts of the body, and self-awareness. There must also be the realisation that to be fulfilled socially requires positive relationships with others and a sense of belonging, for example, to family or organisations. Ward advocates that secondary goods provide concrete ways of achieving primary goods, for example, through good communication skills.

Ward states that the conception of 'good lives' has a number of interrelated features. First, human goods are objective, and if pursued, result in

potentialities that are distinctly human. Second, human wellbeing comprises of a number of goods that contribute to it, but are also valuable in themselves, such as physical health, knowledge, and relationships. Third, human goods are individual and only exist in relation to a person's particular set of circumstances, abilities, and opportunities; there is not one recipe for all. Fourth, human wellbeing is a self-directed activity and therefore arises from each individual's own choices and effort; it is under the control of the individual. Fifth, because human beings are mutually interdependent they can only achieve human goods if others provide them with the necessary social, physical, and psychological nourishment. Finally, the conception of 'good lives' should be coherent, and the relationship between the goods and the conditions necessary for achievement of such a life should be outlined.

The origin of human goods

The idea of human goods appears to have originated with Kekes (1989) and become further developed by Arnhart (1998). They argue that human goods are '*natural*' because they are rooted in human nature and therefore will manifest in some manner across situation and time. According to Arnhart there are at least 20 different kinds of natural desires or goods ranging from friendship, wealth, sexual mating, parental care, and religion. The research indicates that individuals are naturally inclined to seek human goods (Kekes, 1989).

Deci and Ryan (2000) developed the Self Determination Theory of Needs, which advocates that human beings are inherently active, self-directed organisms that are naturally predisposed to seek autonomy (self-

regulation), relatedness (establishing a connection to others, and seeking goals of feeling loved and cared for), and competence (to seek challenges and accomplish goals). They profess that individuals can only flourish if their human needs are met. Failing to meet them will result in distress and maladaptive coping mechanisms or defences. Individuals will then substitute failed human needs with substitute ones that are likely to result in a poorly-integrated self, unsatisfying relationships, and a sense of hopelessness. Deci and Ryan (2000) further argue that the fulfilment of all three needs will result in a deeply satisfying life.

External conditions are also important in the fulfilment of human needs. Conditions such as social, cultural, and interpersonal factors play a role in facilitating the development of psychological characteristics such as skills, attitudes, beliefs, and values. Parenting, education, work and social support, and the opportunity to pursue valued goals are critical in facilitating desired human needs.

In summary, Ward (2002) informs us that as human beings we naturally seek primary goods. They are called 'goods' because they are seen as desirable and valued. The three classes of 'primary goods' are physical/body, self, and social life. Ward states that a conception of good lives should be based on these three classes of primary goods, and specifies the forms they take in each individual's life plan. The specific form that a conception takes will depend on the actual abilities, interests, and opportunities of each individual and the weightings he or she gives to specific primary goods.

The relevance of 'good lives' to offender rehabilitation

Traditionally, working with offenders has focussed on their deficits and criminogenic factors, a target of the 'What Works' theory. Rehabilitation is often about forced treatment or training for the good of the community. For the offender this is not a rewarding approach. The application of positive psychology through the 'Good Lives' model encourages offenders to take part in treatment programmes because of intrinsic goals (e.g. improving the quality of their life) as well as extrinsic goals (e.g. to look good at parole boards, or in front of judges).

In reviewing the 'Good Lives' model and its relevance to offender rehabilitation, Ward (2002) concluded that rehabilitative programmes by the very virtue of what they are trying to achieve, allude to goals or values. Ward further evidences this by reference to a sex offender treatment programme. Ward (2002) argues that 'offenders who are serious about relinquishing an offending lifestyle seek primary goods or valued outcomes'. He goes on to say that these primary goods are crucial components of offender rehabilitation. Sex offender programmes focus on the following clusters or problems that are typically found among adults who sexually abuse children: emotional regulation problems, intimacy deficits, deviant sexual arousal, and cognitive/empathy distortions (Marshall, 1999). These core clusters or problems are typically the foci of sex offender treatment programmes. The ethos of primary goods is evident within each of these clusters. Ward (2002) suggests that seven core components underlie effective treatment for child molesters and exist alongside these primary

goods or values. He summarises the primary goods addressed within these components in the following way:

1. **Norm building:** this is the acceptance of personal responsibility and respect for others. In addition it is about linking the offending behaviour with the meeting of his needs at the expense of the victim. Ward advocates that the primary goods of the self and social life are addressed in this component and assists in motivating the offender to acquire a new understanding of his abusive behaviour;
2. **Cognitive restructuring:** in this component Ward says that the major focus is on the values that are associated with knowledge generation. Also self-esteem issues are addressed and the therapist encourages thoughtful and honest answers;
3. **Empathy distortions:** the primary goods addressed in this area concern the need to take perspective when interacting with others. Offenders are reminded about the consequences of abuse on the victim and the need to value the needs of others alongside his own.
4. **Relationship skills:** the goods associated with different types of relationships are explored, the aim being to provide offenders with the capacity to form deeply satisfying, supportive, and intimate relationships and thus cease to use deviant sex as a substitute for such relationships.

He cements the theory further by examining the differences between offenders who desist and those who persist in committing further crimes.

Finally, he advocates that all rehabilitative treatment programmes for offenders should be explicit with the good lives concept. By this he means that every programme ought to have a conception of 'Good Lives' underlying its assessment and treatment strategies.

The 'Good Lives' Model applied to Sex Offender Treatment

The treatment of sexual offenders has been a longstanding contentious issue. It raises debate not only amongst professionals as to what is the most effective treatment for this population, but also concern from the community about what is being done to ensure public safety. Treatment has progressed from the early days of '*nothing works*' (Martinson 1974) to well-established theories (Marshall, Ward, and others). In addition, research evidence (Friendship, et al. 2002) highlights that offenders who participate in cognitive behavioural programmes, such as sexual offender programmes are less likely to re-offend, as evidenced by reduced re-conviction rates.

Over the past two decades treatment for sexual offenders has generally been from a punitive perspective rather than a positive approach (Ward and Stewart, 2003). There has been a switch from relapse prevention models to self-regulation, which acknowledges that individuals follow different pathways. This incorporates the multiple and diverse factors that lead to offending with treatment and is then adjusted accordingly.

The 'Good Lives' model has now been included within this new mode of treatment for sexual offenders. In the 'Good Lives' model individuals are regarded as active goal-seeking individuals who seek to acquire fundamental primary human goals. Among sexual offenders, risk factors

and criminogenic needs may then be seen as symptoms or markers of ineffective or inappropriate strategies employed to achieve these goods or goals. For example, an offender may desire intimacy, but turn to children to meet this need. Ward (2002) says that essentially criminal behaviour results from problematic methods used to achieve goals and not from the goals themselves. The aim in treatment then is not to change the goal (intimacy), but to target the methods the individual uses to achieve the goal (achieving intimacy with children).

The CFMHT currently deliver cognitive behavioural programmes for their client population. This population includes offenders with a wide range of offending history. Within these programmes the 'Good Lives' approach is advocated. Offenders are encouraged to develop a set of goals for their lives and through the course of the programme are encouraged to develop these and work out methods for achieving them in a way that increases their own personal wellbeing and manages their risk. The current research will investigate the effectiveness of this, and whether from a patient perspective the 'Good Lives' model is meeting its objectives.

In advocating the 'Good Lives' model, Ward et al. (2007) also review Andrews and Bonta's, (1994) 'Risk-Need-Responsivity' theory. Ward et al. (2007) argue that 'Risk-Need-Responsivity' has been criticized regarding a failure to appreciate all of the client's needs, specifically with respect to offender responsivity concerns. The 'Good Lives' model argues that sex offender treatment must be holistic and focus in many areas of an individual's life, not just the offending (e.g. family, employment, leisure, community, personal wellbeing). He argues that the 'Risk-Need-

Responsivity' and 'Good Lives' models should be complementary, and that bringing out the strengths of each model will enhance overall offender management and general wellbeing whilst at the same time increasing public safety.

Ward et al. (2007) contend that in order to truly address risk, a holistic approach must be adopted; the 'whole person' should be treated rather than merely focussing on that person's criminogenic needs. Not only does the current research aim to explore how effective a community forensic team is in adopting this approach but also seeks to identify what is important from the individual's perspective, i.e. the mentally-disordered offender.

Reviews of 'Good Lives' Model

The 'Good Lives' model is a new theory of offender rehabilitation and therefore is in its relative infancy in comparison to the 'What Works' model and 'Risk-Need-Responsivity' model with respect to application of treatment interventions for offenders and critical evaluation. However, a number of studies have reviewed the efficacy of the 'Good Lives' model and these are outlined below.

Ward, Polaschek, and Beech, in their book 'Theories of sexual offending' (2006), identify a number of weaknesses with the 'Good Lives' model. It is stated that the definition of primary goods is problematic because it contains two contrasting interpretations. Primary goods are defined as activities and experiences that are sought for their own sake and intrinsically motivate offenders. However, they are also viewed as experiences that are beneficial to human beings. Ward et al. point out that these two definitions are not

always coupled and it is possible that a person may be engaging in a behaviour that although motivating is actually harmful.

The second problem argued is that it is not clear as to whether the 'Good Lives' model is of additional value to the already established risk management approach, particularly with the sex offender population, and it is suggested that this requires empirical attention. How much added value is there in adopting the 'Good Lives' model to existing risk management approaches such as 'Risk, Need Responsivity'?

The third criticism proposed is with regard to empirical support. Here it is stated that there is little or no evidence for the assessment and treatment aspects of the theory and therefore it lacks 'empirical adequacy'.

The current research study aims to further explore the value of using a 'Good Lives' approach in the community with a mentally-disordered population thus highlighting whether there is empirical evidence for the approach in an offender population other than sexual offenders. Of particular interest will be the application of the 'Good Lives' model within a Northern Ireland context. One of the primary goods quoted by Ward is spirituality/religion. Northern Ireland has experienced religious and cultural divides over the years and the implementation of this primary good for people to its full extent has been difficult. In the current study the impact of religious and cultural conflict with regard to the full implementation of the 'Good Lives' model will be examined.

A recent study by Simons, McCullar, and Tyler (2008) found that a 'Good Lives' model focus in treatment with offenders resulted in significantly higher

rates of treatment engagement and completion, significantly lower rates of attrition, higher levels of motivation, and greater within-treatment change in areas such as coping skills, as compared to treatment using the standard Relapse Prevention model.

Reviewing the 'Good Lives' model, Wilson and Yates (2009) advocated that the 'Risk-Need-Responsivity' theory and the 'Good Lives' model are complementary. They emphasize the merits of both theories/models but have suggested that further work is required on the theoretical underpinnings of each.

Maruna (2001) advocated that the 'Good Lives' model assists in the development of a new narrative or new personal identity and the desistance from crime amongst offenders generally.

2.9 Limitations of the Research, and Summary

The efficacy of 'What Works', 'Risk-Need-Responsivity' and 'Good Lives' is evident within the field of offender rehabilitation. What appears to be missing from research is how effective they are with specific offender groups. The 'Good Lives' model demonstrates the value of this approach with sex offenders, and indeed this theory has been incorporated within some cognitive skills programmes for offenders generally.

What the research also appears to be highlighting is that in undertaking assessments of risk and rehabilitating offenders we need to be adopting a multi-modal approach. 'Risk-Need-Responsivity' focuses on the risk and need principles and also public safety. However, we also need to look at the

individual as a totality and adopt a person-centred approach. Maruna's work on 'desisters' of crime (2001) highlights the importance of this.

The current research will examine the effectiveness of the theories as applied to mentally-disordered offenders within a community context. Much research on the effectiveness of offender rehabilitation has been conducted within prisons and secure hospitals or within the community context of the probation service. What will be particularly novel about the current research study is the application of these theories to mentally-disordered offenders in the community, and the impact they have on the offender and their family. Differing levels of risk of re-offending between secure services and the community may impact on an individual's experience of the treatment they receive. For example, individuals in the community have more freedom and as such may experience a higher degree of satisfaction with the service they receive. These are important considerations when exploring the value of a rehabilitative model with an offender population.

2.10 Northern Ireland Policy Recommendations for Mentally-Disordered Offenders

The Bamford Review Recommendations (Northern Ireland)

The Northern Ireland Bamford Review ('The Bamford Review') was undertaken in 2006. It established a number of key principles and recommendations as to how community forensic mental health teams in Northern Ireland should operate. These recommendations are included and referred to in Chapter 1. A Bamford action plan (2009-2011) by DHSSPSNI (Department of Health and Social Services and Public Safety Northern Ireland) was prepared in response to the Bamford Recommendations

(2007). For CFMHTs in Northern Ireland the action plan advocated the following:

- *‘The development of training needs analysis to assist collaborative working and meaningful communication. The intention of this is to support the development of forensic services in a strategic and co-ordinated manner’;*
- *‘Establishment of a Northern Ireland Forensic Network involving service users and carers to support the development of forensic services in a strategic and co-ordinated manner’;*
- *‘Undertake a review of current provision of low secure and community forensic placements and assess the need for further investment’;*
- *‘To develop appropriate standards and protocols for dealing with people detained in Police Stations’;*
- *‘To review strategy for people with a personality disorder. This group are significantly over-represented in the CJS’.*

Working groups have been established to take forward the above actions.

This is currently a work in progress.

2.10.1 Limitations of the Research, and Summary

To date no research in Northern Ireland has investigated whether CFMHTs have met these recommendations and indeed whether, in respect of CFMHTs, they are in line with offender rehabilitative theories such as McGuire’s ‘What Works’ theory. For example, has the service met the ‘What Works’ principles? If so, how, and if not, why?

It will be of scientific and public interest to ascertain if the needs of mentally-disordered offenders have been met according to The Bamford Review recommendations, and indeed whether they are currently relevant to forensic psychological practice in Northern Ireland and meet the principles of McGuire's 'What Works' theory or not. Research on this will be undertaken from three service user groups' perspectives: (1) patient/client (2) family/carer (3) professional. The research should highlight lessons learned that will inform the future policy development of CFMHTs.

2.11 Involving Service Users in Research

2.11.1 Introduction

Improving the patient's experience of health services is one of the Department of Health's priorities (Department of Health, 2008). Current NHS guidance on research and governance states that consumer involvement should exist at every stage of research, where appropriate (Department of Health Research Governance Framework for Health and Social Care, 2001).

In the UK consumers are defined as 'patients, potential patient's informal (unpaid) carers, people who use health and social services and organisations that represent the interests of people who use health and social services and members of the public who may be the potential recipients of health promotion plans'. (Involve – promoting public involvement in the NHS; www.invo.org.uk).

Traditionally, it appears to have been the opinions and perspectives of the professionals that have been used to inform the effectiveness of services, whilst mental health, learning disability, and forensic service users appear to be some of the most alienated groups when sourcing the opinions of service users. There appears to have been a sense that people with a diagnosis of mental illness or learning disability were not able to provide valid views (Weinstein 1981). Goodwin, Holmes, Newness, and Waltho (1999) nonetheless argued for a moral obligation to include mental health service users in research.

In the current research study the opinions of the service users, including both the patients and their carer/family, are sought. Unfortunately, there appears to be a lack of evidence as to what constitutes effective user involvement. A number of studies have demonstrated that important data can be generated by considering the individual experience of mental health service users.

2.11.2 Research Validating Service User Involvement

Wood, Thorpe, Read, Eastwood, and Lindley (2008) evaluated service-user satisfaction in a low-secure forensic learning disability unit. Using qualitative methodology through semi-structured interviews, they identified themes relating to two areas, Detention and Treatment. Findings supported predictions that individuals with a learning disability could give valid views about their treatment. There were overlaps between the findings of this research and previous studies that considered the views of mental health/forensic and learning disabled service users.

Simpson and House (2002) undertook a systematic review of randomised controlled trials and other comparative studies involving users in the delivery or evaluation of mental health services. The studies that they identified suggested that users of mental health services can be involved as employees, trainers, or researchers of such services without damaging them.

Simpson and House (2002) also suggest that users with a history of severe disorders can be involved in both services and evaluations of services. This may depend on adequate support; all of the studies include details of the support provided to service users. Service providers gave practical and personal support to users, for example, discussing issues of confidentiality, and participating in focus groups. The outcomes of these studies are of particular relevance to the current research, in which service users are primarily patients, who by definition have a severe and enduring mental illness. Clearly they will require support and guidance and potentially training, particularly if participating in the qualitative aspects of this research, i.e. focus groups.

There are limitations to Simpson and House's (2002) research. They highlight that most of the studies they reviewed involved few users and had substantial methodological weaknesses. Furthermore, most of the studies originated in the US. Godin (2005) conducted research between June 2004 and June 2005 on engaging service users in the evaluation and development of forensic mental health care services. Seven service users were involved in this research and stayed with the project for four to nine

months. The aim of the research was to explore service users' experience of using forensic mental health services.

The research project produced useful findings in two major areas. Firstly regarding the processes and problems of undertaking such research; secondly the qualitative data generated by the service users produced a detailed picture of how forensic mental health care was/is for them.

Detailed below are significant findings from this research. These have helped inform the current research:

1. Service users were concerned that the relationships they had with staff were often far from therapeutic and wished staff might be more understanding of the people they cared for;
2. Service users expressed concern about the major side-effects of psychiatric drugs and their questionable therapeutic value;
3. Service users thought that the greatest improvement could be made to services by ensuring therapeutic relationships between staff and patients. More than anything they felt staff could be more open and honest with them;
4. Service users wished that the service could be more accountable, and could help them overcome the social stigma they faced;
5. Services users also felt that at times within secure provision they felt like they were deep within a hole from which there was little chance of getting out.

In view of the above findings the lead researchers made the following recommendations:

- *‘Anybody attempting to undertake further participatory research in forensic mental health should be prepared to meet challenges such as service user’s reticence to become involved’;*
- *‘Once service users become involved, tolerance is required to accommodate the limits they place on their participation’;*
- *‘To ensure the integrity of the research it important for it to remain separate from service provision and therapy’.*

Government policy in the UK Department of Health (2004) strongly supports the development of involving users in the delivery and evaluation of mental health services. Clearly, this current research is required and will produce important recommendations in this much under- researched area.

Coffey (2006) conducted a literature review of research on service users’ views in forensic mental health. He found that the volume and breadth of research studies that explored the views of service users was limited. Overall, his review highlighted that service users indicate positive and negative experiences of services received. In particular, concern regarding stigmatisation was highlighted, as well as restrictions on their freedom. In conclusion, he stated that the knowledge base of the experience and perspectives of people who use forensic mental health services is limited and further research is required in this area.

2.11.3 Benefits of Involving Service Users in Research

The Sainsbury Centre (2001) conducted research entitled ‘Users’ Voices’. The research was ground-breaking in that it was perhaps the first time that individuals with severe and enduring mental health problems had conducted

a major piece of research. The questions were developed and asked by user interviewers which had a major impact on the interviewees' responses (also service users). The interviewers reported back that service users relaxed and opened up once they knew the interviewer *'had also been through the system'* and thus could empathise with their own situations. In the health service we advocate a 'patient-centred approach' thus it makes perfect sense that service users should be involved in research.

The Sainsbury Centre research with service users concluded that involving service users in research can make a difference to their life. Many of the interviewers found they gained substantially in terms of self-esteem. The research proved that mental health service users not only have something to say about the services they receive, but also that what they say is sound and rational, and can be taken on its own merits.

A London-based organisation called User Voice, was established in 2009 by ex-offenders. They focus on Criminal Justice and associated services, including Children's, Social Mental Health, and Alcohol Services. Their aim is to create a model of service-user engagement that is fair for all involved. They seek to foster dialogue between service providers and service users that is mutually beneficial, aiding rehabilitation and recovery, and results in better and more cost-effective services. All staff that work directly with service users have a personal history of offending. 'User voice' believe this is crucial in giving them the insight, credibility, and access to do their job well. Through their organization they have enabled productive collaboration between service users and service providers. This again highlights the

value offenders can have in contributing to policy and service developments (www.uservice.org/our-story/).

2.11.4 Limitations of the Research, and Summary

Research involving service users has a valuable role to play not only in learning more about the patient and the service they receive, but also the positive impact it has on service users, for example, enhancing self-esteem and providing them with a 'voice'. Service users have a valuable role to play in research. There is much research on patient and public involvement generally within the health service but less with regard to the involvement of offenders. This may be to do with professional and public attitudes regarding involvement of this specific group in research. The Department of Health paper (2004) on patient and public involvement in health discusses the value of patient involvement in research and practice, advocating that such discussions can help facilitate positive change in values, attitudes, and beliefs.

Offenders with a severe and enduring mental illness are often the most marginalised group in society. Research, such as 'Good Lives', argues that as well as addressing offending we should also encourage offenders to develop healthy social and physical lives as well as mental wellbeing. We cannot do this unless we 'work with' this population seeking to identify their needs and interests and 'what works' best for them.

The current research study positively involves service users in its research. Although the services users will not be conducting the research they will be

asked for their opinions about the service they receive and will be participants in focus groups.

2.12 Client/Patient Satisfaction with Treatment

2.12.1 Introduction

One of the hypotheses that will be explored in this research study is how the patient/client values the treatment they receive and how satisfied they are with the overall service they receive. As stated earlier, the patient/client perspective, particularly within the mentally-disordered offender population, is often neglected, yet their opinions are likely to be informative and could influence and inform how effective treatment and rehabilitation could be provided. Community models have largely replaced institutional care in many parts of the world, therefore it is important to measure satisfaction and obtain patient/clients' opinions about the services a community model provides.

Patient/client satisfaction is a psychological concept (Irish Study for Quality and Safety in Healthcare, Measurement of Patient Satisfaction Guidelines, 2003), which is easy to understand, but hard to define. The Irish Study for Quality and Safety in Healthcare states that a simple and practical definition of satisfaction would be the degree to which desired goals have been achieved. Satisfaction is an attitude and according to Keegan, McDarby, Tansey, and McGee (2002) it is composed of both cognitive and emotional facets, and relates to previous experiences and social networks. The Irish Study for Quality and Safety in Healthcare conclude in their paper that for patients to feel satisfied concerning their health care they must have a

perception that the quality of care and services they receive has been positive and satisfying, and meets their expectations.

2.12.2 Client/Patient Satisfaction Studies

A core problem in most studies of patient satisfaction is that it is not clear what patients actually mean when they say they are satisfied with a particular aspect of their treatment Dijk, Visschedijk, and Kwaale (2003). High satisfaction does not always mean high levels of quality of care, which means that there are problems in the measurement of satisfaction. Sixma and Vancampen (1995, 1998) suggest a practical approach by assessing the quality of care from the patient's perspective. They focus on the basic components of satisfaction, expectations or 'needs', and experiences. Instead of asking patients whether they are satisfied or dissatisfied they posed open-ended questions about patients' actual experiences in order to obtain opinions and perceptions regarding a range of aspects of their service. When asked to suggest improvements the respondents actually disclosed their needs. In the current study patients will be involved in focus groups and interviews where they will be asked about their experiences of receiving a service from a CFMHT. This study is interested in obtaining the opinions of the service users and their families about how valuable they feel the current approaches of Good Lives, What Works, and matching risk of offending with need.

Dijk et al. (2003) considered it important to assess the priorities that patients have with regard to different aspects of the health service. To facilitate this they utilised different data collection methods, interviews, focus groups, and

discussions. Patients, health staff, and community members were targeted. They included community members as they felt they are also 'clients' of the service and that their opinions on the services can influence health-seeking behaviour. They interviewed professionals in order to compare their views with those of patients. In the current research study a similar approach will be adopted, although instead of the 'community' the patients' families/carers will be involved. The results of the Dijk et al. (2003) study led to the development of guidelines that explain in a step-by-step basis how a study of client satisfaction can be organised and conducted, namely: (1) planning and preparation, (2) fieldwork, and (3) analysis and write-up. They acknowledged that it allowed them to gain good insight into the quality of the service.

Interestingly, the Dijk et al. (2003) study found that the methods of data collection, involving focus groups and interviews, were in themselves a positive process for patients to engage in. Patients had the opportunity to express their opinions and gain a sense of awareness that they had the ability or power to improve their situation. This would be a positive secondary outcome of the current research study as patients will have the opportunity to discuss their experiences of treatment. Furthermore, in the Dijk et al. (2003) study, professionals indicated that new issues that they had not previously thought about were discussed during the interviews, and hence a process of self-analysis and reflection was generated which possibly led to new insights into their own functioning.

In a review of the literature researching patient satisfaction, Naidu (2009) found that health care quality is more difficult to define than other services (for example financial), because it is the patients themselves and the quality of their life that are being evaluated. To overcome this issue, the research suggests (Strasser, Schweikhart, Welch, and Burge 1995) that taking family perceptions into account can assist in assessing the quality of the patients' health care. The perceptions and attitudes of the client's family will be sought in the current research study.

In summary, a number of key themes have emerged from research on service user satisfaction. Themes include:

- Satisfaction with activities;
- Satisfaction with staff care, for example, information given by staff, politeness, helpfulness, and perception of whether staff were interested in the patient and made time to talk;
- Satisfaction with information about, and involvement in, treatment programmes. Lack of information really appears as a crucial determinant of dissatisfaction with psychiatric care among both patients and their relatives;
- Satisfaction with the physical environment.

The role of the above variables will be examined in the current study to determine their significance for mentally-disordered offenders and the service they receive from CFMHTs.

2.12.3 Measurement of Patient Satisfaction

The Irish Study for Quality and Safety in Healthcare, Measurement of Patient Satisfaction Guidelines (2003) identified the need for a national standardised approach to the measurement of patient satisfaction. A project team was established in response to the National Health Strategy: 'Quality and Fairness: a Health System for You' (DOHC, 2001). The team consisted of nominees from The Health Board's executive, The Irish society for Quality and Safety in Healthcare, and the Health Services National partnership Forum. The project team advocated that feedback from patients/clients 'can influence the whole quality improvement agenda and provide an opportunity for organisational learning and development'. It is hypothesised that this will be a secondary outcome for the current research study. They went on to say that feedback provides crucial information on what the patients/clients' expectations are, and how they perceive the quality of care, which may be different from that of all staff providing that care. They emphasised the need for a structured framework to collect information about patient/client satisfaction to ensure a 'systematic methodology' to facilitate benchmarking and feedback into the overall decision-making process.

Gerber and Price (1999) measured the satisfaction of seriously mentally ill patients within an assertive community treatment programme in Ontario, Canada. The treatment programme's team included a psychiatrist, social worker, and counsellor. They used a 35-item questionnaire to measure satisfaction and distributed the questionnaires by mail. This instrument was developed by Hanson (1989) to assess satisfaction within outpatient psychiatric care. They chose this instrument as it addresses a wide range

of relevant service issues. The 35 items cover the location in which the service is delivered, obtaining services, clients' input into treatment, satisfaction with treatment, access to clinical files, satisfaction with the therapist, family involvement in treatment, and overall satisfaction. They had a return rate of 51% and found this approach to be an efficient way to collect data anonymously from persons with serious mental illnesses.

The key findings in the Gerber and Price (1999) study were that clients would like to spend more time with their key worker. This supports the idea that the client or patient relationship is extremely important. The study also highlighted specific patient/client needs to members of the community treatment teams. As a result of Gerber and Price's research, changes were implemented in the Ontario community treatment programme for mentally ill clients, such as giving clients a written summary of their treatment plan and revising their medication policy to reinforce information given to clients about the side effects of medications. They also made recommendations for further analysis which included: receiving a service at their residence instead of at a clinic and receiving services from multiple team members rather than a single clinician.

2.12.4 What Factors Influence Patient Satisfaction?

Research by Gigantesco, Picardi, Chiaia, Balbi, and Morsoni (2002) have also highlighted that satisfaction with services can be influenced by differing patient characteristics:

- Having a diagnosis of psychosis was related to poor satisfaction in patients with schizophrenia or other psychotic disorders. It is also

interesting to note from Gigantesco et al.'s (2002) research that poor satisfaction has recently been reported in a sizeable proportion of caregivers of patients with schizophrenia;

- Being in contact with psychiatric services for more than 6 years appears to lower levels of satisfaction;
- Patients who are single appear to be less satisfied with services than those who are married;
- Gigantesco et al. also found that younger patients were less likely to be satisfied than older patients, a finding which is in agreement with some previous studies, for example, Greenwood, Key, Burns, Bristow and Sedgwick, (1999);
- From a patient satisfaction perspective, there is also evidence that antisocial and paranoid personality traits among psychiatric patients are particularly associated with low levels of satisfaction with care and treatment (Svensson 1994). Svensson suggested that scoring high on a measure of psychopathy such as the PCL: SV, is congruent with the desire to have autonomy regarding rules, regulations, and relationships, and suggested that it is possible that patients with psychopathic traits find it hard to adjust to restrictive environments such as secure psychiatric in-patient facilities.

Naidu, (2009) reviewed factors determining patient satisfaction and quality. Overall he found that the quality of healthcare affects patient satisfaction, which in turn impacts on 'positive patient behaviours' such as loyalty.

The Irish Study for Quality and Safety in Healthcare (2003) identified the following as factors that influence satisfaction:

- Literacy levels;
- Intellectual and physical/sensory disability levels;
- Social elements such as educational status, financial status, demographics/urban/rural and technology;
- Age: older respondents generally record higher satisfaction; possible explanations include lower expectations of healthcare and a reluctance to articulate dissatisfaction;
- Poor prior experiences of satisfaction: Crow, Stoney, and Page (2003) in their review of literature identified that satisfaction was linked to poor prior satisfaction with services;
- Patient/client professional relationship: Crow et al. (2003) argued that consistent evidence across settings suggested that the most important health service factor affecting satisfaction is the patient/client relationship including the provision of information from the professional and their technical competence;
- Choice of service provider: choice is associated with higher satisfaction. Where patients have little or no choice in their treatment, or are assigned to it, poor satisfaction is evident;
- Gender, ethnicity, and socio-economic status: evidence about the effects of gender, ethnicity, and socio-economic status is equivocal due to limited research;
- Illness: patients with chronic disease have shown consistent patterns in satisfaction with health care (Thiedke, 2007). Patients with two or more chronic illnesses reported more hassles with the health care system than those with a single chronic illness.

These themes and patient characteristics are of relevance to the current research and were of importance when considering the methodology and design of focus groups, interviews, and questionnaires. Illness as a factor is particularly important as many patients receiving a service from the CFMHTs have co-morbidity, often suffering from more than one illness.

2.12.5 Limitations of the Research, and Summary

It is clear from a review of the literature that measuring patient satisfaction is a positive process. Not only does it inform service delivery but it also empowers the patient and may increase self-esteem and confidence. There is a wealth of research in this area. However, Theidke (2007) notes most patient satisfaction studies appear to be based on patients' experiences at one given time, rather than their experiences over a life time. The current study examines the attitudes and satisfaction of patients who may have been a patient of the CFMHT for several years.

A further limitation is the lack of research on patients' attitudes and feelings towards the quality of service/care they have received or are receiving. This may be due to a perception that patients are unable to interpret 'quality' due to not being technically trained in the treatment they are being provided with. This is an interesting area to explore and the current research will address this through focus groups, interviews, and questionnaires.

It is also important to note, however, that in measuring patient satisfaction, responses can be influenced by characteristics of the patient. This will be an important consideration in the current research. It will be interesting to note if different characteristics, for example, age and perhaps type of mental

disorder, influence levels of satisfaction with the treatment provided. Furthermore, it will be useful to determine what characteristics of the CFMHT influence patient satisfaction. For example, having a named key worker, participating in a cognitive behavioural group, being seen at home rather than in a hospital, preferring a Good Lives approach or a focus on risk of re-offending. These will be interesting to determine and will serve to inform treatment practice and what works with this type of offender, namely mentally-disordered offenders living in the community.

2.13 Patient/Therapist Relationship

2.13.1 Introduction

In the current research the term 'offender' can be regarded as synonymous with the term 'patient' and hence the patient-therapist relationship will be explored. Specifically it is hypothesised that offenders who report having a strong therapeutic relationship with their therapist or key worker are more likely to desist from offending. The research in this area relating to this hypothesis will now be reviewed.

In their work on the rehabilitation of offenders, in particular sex offenders, Marshall, Anderson, and Fernandez (1999) illustrated the importance of effective therapist characteristics and behaviours such as warmth, respect, and use of positive reinforcement. They profess that these characteristics are essential for treatment effectiveness. This goes above and beyond the 'What Works' and 'Risk-Need-Responsivity' approaches where often the sole focus is on risk management. Marshall and his colleagues advocate

that such models do not provide therapists with enough tools to engage and work with offenders in therapy.

Cahill, Barkham, Hardy, Cilbody, Richards and Bower (2008) outline three developmental processes that they argue are necessary for the provision of an effective therapeutic relationship.

These are:

1. Establishing a relationship;
2. Developing a relationship;
3. Maintaining a relationship.

They also identified that the therapist, patient, and contextual factors determine the nature of the roles and frameworks within which the therapeutic relationship takes place. They advocate that these in turn impact on the processes and outcomes of each phase of the relationship. Each of these processes will now be reviewed.

1. **Establishing the relationship:** Cahill et al. (2008) advocate that there is clear evidence that early development of a good relationship between therapist and patient predicts the better outcome of remaining in therapy. For example, 'engagement objectives' should be established, involving a discussion of the expectations of the patient and therapist, and intentions and the role of motivation and hope in the therapy. They also argue that adopting a warm and empathic approach where there is a negotiation of goals, support,

and guidance is critical to the relationship in addition to affirmation and adoption of a collaborative framework.

Empathy is particularly linked to positive outcome in the therapeutic relationship. Empathy is the ability of the therapist to enter and understand both affectively and cognitively the patient's world. The patient's experience of empathy is important in the development of the relationship (Whinston and Coker, 2000). There is also evidence that the negotiation of goals is important in the early stages of therapy, for example in treatment plans.

2. **Developing the relationship:** Cahill et al. (2008) propose that developing the relationship between the therapist and the patient involves a number of therapist techniques that help in progressing the relationship. These are:

- **Exploration and reflection** – increased use of exploration is associated with more positive relationship ratings (Whinston and Coker 2000);
- **Secure base** – this is derived from attachment theory and describes how safe and secure a patient feels in therapy. Patients need to feel secure in order to explore their problems;
- **Feedback** – this is where the therapist provides feedback to the patient, for example change promoting messages and positive reinforcement. Positive feedback helps to establish

and strengthen the relationship. (Claiborn, Goodyear, and Horner, 2001);

- **Relational interpretations** – Cahill et al. (2008) state that several studies have linked the use of relational interpretations to outcome, concluding that high levels of transference interpretations should be avoided and the primary focus of interpersonal interpretations should involve the central interpersonal theme of the patient;
- **Non-verbal communication** – non-verbal behaviour is important in therapy as it provides information about the patients' emotional state and can be used as a tool for improving the therapist-patient relationship. For example, laughter and humour are described as indicating positive change in the patients self-concept i.e. how they view themselves, (Cahill et al. 2008);
- **Transference** – the concept of transference is complex; however, it is essential to those therapies that propose that the therapeutic relationship is the vehicle for the process of change;
- **Self-disclosure** – Cahill et al. (2008) state that patients are often more positive about therapist self-disclosure than therapists. However, the positive effects on either the relationship or therapy outcome have yet to be demonstrated. Because of this it is recommended that therapists only

infrequently disclose and if so it should be done in a positive way to validate or normalise behaviour.

3. **Maintaining the relationship:** Maintaining a positive patient therapist relationship is an ongoing challenge. This is particularly the case within the field of offender rehabilitation and with mentally-disordered offenders, where it takes some time to develop a positive relationship of trust. Therapists can often have negative feelings towards patients. Harris (1999) suggests that this has been shown to result in a decrease in patient functioning during treatment. For example, therapists imposing their own values, making irrelevant comments, being critical, rigid, and uncertain can have a negative impact. Patient behaviour also has an impact. For example, the patient hiding negative feelings towards the therapist such as anger, hostility, and fear has been linked to poorer outcome (Bachelor and Horvath, 1998). Flexibility is associated with positive relationships as is responsiveness to the patient's requirements (Stiles, Hones-Webb and Surko, 1998).

The patients' particular attachment styles have been found to influence the quality of the therapeutic relationship, with patients who have insecure attachment styles less able to form satisfactory alliances. Patients with an avoidant attachment style are particularly hard to engage in therapy (Bachelor and Horvath, 1999).

The roles each person plays in the interactions between therapist and patient are important to consider. Therapists' roles have been

identified through research as friend/companion, advocate, attachment figure (provide secure base), and expert/authority leader (helps build patients' expectations) (Corrigan, Dell, Lewis, and Schmidt 1980).

Overall, the evidence suggests that in managing the therapy process, a collaborative framework is important for maintaining an effective therapeutic alliance (Gartner, 1997). However, some patients also benefit from a more directive and structured approach, and this helps to maintain expectations and motivation (Campbell, 1996).

2.13.2 Limitations of the Research, and Summary

The research in this area suggests that a good relationship between therapist and patient is necessary, particularly early in therapy. Patients highlight the importance of warmth and involvement at this stage, and therapists judge the quality of the relationship on active participation and collaboration. Contextual factors impact on the development of the relationship. Maintaining the quality of the relationship requires the therapist to be responsive to the needs of the patient. The research literature highlights that this is particularly the case in offender rehabilitation, but the evidence is limited due to an absence of adequate research on CFMHTs in Northern Ireland. In the current research study the patient or offender relationship with the therapist will be explored in this context. How much value is placed on the relationship by both parties, and the relevance to treatment outcome and reduction in offending will be an important part of each of the three research studies to be undertaken.

2.14 Summary and Overview

The literature review highlights a lack of research in the area of CFMHTs. There appears to be a lack of research identifying what works best with this client group and their family. There is a need to conduct further research in order to inform the best type of treatment for mentally-disordered offenders in the community.

One of the ways in which the current research will do this is to investigate empirically the relevance of rehabilitative theories for mentally-disordered offenders in the community. Three major theories in this area will be explored, namely: 'What Works', 'Risk-Need-Responsivity' and 'Good Lives'. In exploring these theories the benefits for the offender and their family will be identified. In addition the perspective of professionals who are involved in working with offenders will be sought.

The literature review suggests that there are strengths and weaknesses to each theory. This research seeks to identify these in more detail and identify what works the best in terms of recidivism, wellbeing, and improved mental health. The theories apply different psychological approaches, from cognitive social learning theory to positive psychology and a strength-based approach. The research may identify that a particular approach is more beneficial for the mentally-disordered offender.

The attitude of the service user and their family/carer is an important component in ensuring long-lasting change from treatment. Thus it is important to research the feelings and perceptions of service users towards their treatment and identify critical factors for success.

One of the secondary outcomes of this research study will be a series of recommendations for how CFMHTs in Northern Ireland should operate. To date there has been no research on CFMHTs in Northern Ireland, and so the study will produce a pool of data that can be used for future research studies. The results may also be applicable for other CFMHTs in the UK.

Ultimately, the research is striving to identify a treatment service for mentally-disordered offenders in the community that is responsive to their and their family's needs, promotes wellbeing and improved mental health, and satisfies the public in terms of community safety.

CHAPTER 3

RATIONALE FOR THE RESEARCH

3.1 Introduction

This section discusses the rationale for the research project. The current research is being undertaken to identify the treatment interventions that work best with mentally-disordered offenders in the community, from the perspective of three different service user groups. Differences in attitudes between the three service user groups will be explored. A review of academic literature in this area indicates that there is a lack of research for community forensic mental health teams in this context. Specifically, there is little research that evaluates the experience of services users with CFMHTs.

There were a number of aims and hypotheses to be explored, namely:

1. **Aim & Hypothesis:** Aim: To find out whether interventions and treatment programmes delivered by the Community Forensic Mental Health Team in Northern Ireland adhere to empirically-based rehabilitative models for offenders. In addition, what impact these models/theories have on the offender and their family. Hypothesis: It was hypothesised that the Community Forensic Mental Health team deliver treatment interventions that are empirically-driven and evidence-based.
2. **Aim & Hypothesis:** Aim: To discover how satisfied offenders and their families are with the community forensic service; the value they

place on the service and their understanding of the current approaches and rehabilitative models adopted and applied. Hypothesis: It was hypothesised that the three groups would report satisfaction with the service received from the Community Forensic Mental Health Team.

3. **Aim & Hypothesis:** Aim: To explore the relationship between the therapist and the offender. Hypothesis: It was hypothesised that the three groups would identify the importance of a strong therapeutic relationship between therapist and offender for treatment intervention and risk management.
4. **Aim & Hypothesis:** Aim: To explore the legacy of the troubles in Northern Ireland on the treatment and rehabilitation of offenders and their families. Hypothesis: It was hypothesised that the legacy of the troubles may have impacted negatively on the treatment and rehabilitation of mentally-disordered offenders receiving a service from a CFMHT in Northern Ireland.

Three separate studies were undertaken to explore the above aims and hypotheses. The approach adopted was mixed methods and included Focus Groups (Study One), Questionnaires (Study Two) and finally Semi-structured Interviews (Study Three). Ultimately, the research was looking to identify what particular elements are important in rehabilitating mentally-disordered offenders in the community. Is it about the approaches adopted and the theories applied? How important is the therapeutic relationship? What role does satisfaction play in treatment outcome and re-offending?

3.2 Lack of Research – Community Forensic Mental Health Teams Northern Ireland

The focus of the research is treatment interventions with mentally-disordered offenders within the context of a Community Forensic Mental Health Team in Northern Ireland. In recent years there has been a shift from inpatient care to care in the community. One of the main advocates for this was the Reed Report, which was outlined in Chapter 1. In summary, the Reed Report highlighted that people with mental health difficulties and forensic histories should be supported in the least restrictive environment as possible. The researcher has worked within a community forensic mental health team for several years, which informed the need for identifying the key 'ingredients' for treating mentally-disordered offenders in the community.

There is a lack of research about effective interventions in the context of psychological theory with this client group. Community forensic mental health teams aim to provide appropriate treatment and care in the community for people with mental health problems and a forensic history. However, there is limited empirical research evaluating what specifically 'works' with this population. Existing research has largely focused on the different models of community forensic mental health teams such as the parallel and integrated model rather than the effectiveness of the treatment provided.

There is also an absence of any exploration as to 'what works' from the perspective of the patient/client, the care providers (professionals), and also

the patient's/client's family members. Even less is known about what works with this population in Northern Ireland.

Original and Relevant

The research is original as it is seeking to evaluate the relevance of psychological/offender rehabilitative models from three different perspectives: the patient, the family, and the professional. It also considers the role of other variables such as the impact of relationships, an organisation's culture, and the culture of the environment on offender rehabilitation. This will add to the current models, or perhaps lead to the development of a new model in offender rehabilitation.

3.3 Rationale for Data Collection Methods – A Three-Study Mixed-Methods Approach

In order to fulfil the aims of the research a mixed-methods research approach has been adopted in the three studies undertaken. Quantitative and qualitative research methods have been utilised to encapsulate a wider range of both implicit and explicit perspectives through the conducting of the studies. The analysis and interpretation of the emerging data from both approaches at various stages of the process was examined for linkages and cross-cutting issues to better inform subsequent studies. In essence this is a developmental approach using one method to answer certain questions that could then inform the next study and so on, in a manner highlighted by Creswell and Plano Clark, (2007, 2011).

Quantitative and Qualitative Research Methods

In order to inform the first part of the research, the views of the service users (patients), their families, and those providing interventions (professionals) were sought through focus groups. These views then informed the development of questionnaires in order to further address the main issues under study. In this way, the accepted practice of using qualitative research in order to gather information in order to inform and develop a later quantitative study was applied. (Heffner, 2004) As a result, it was anticipated that the data obtained from the questionnaires would have greater rigour and reliability.

In order to develop further information obtained from the focus groups and questionnaires, semi-structured interviews were then conducted with a small subset of the sample, to provide a more descriptive meaning and in-depth analysis. In making sense of the personal experiences of the participants, Interpretative Phenomenological Analysis (IPA) approach (Smith, 1966) was applied to help give a better insight into the therapeutic relationships and the interactions between participants: the patients, their families, and the professionals.

Applying the principles of IPA methodology meant securing an account of the participant's experiences of specific services delivered by the Community Forensic Mental Health Team and completing a detailed analysis of the meanings attached to those experiences.

3.4 Epistemology Approach.

Wiersma, (2000) and Delanty, and Strydom (2003) define epistemology as the study which investigates the possibility, limits, origin, structure, methods, and truthfulness of knowledge and how knowledge can be acquired, validated, and applied. According to Brewerton and Millward (2001), the term refers to the inquiry of what differentiates defensible belief from opinion. Ontology is also considered relevant. Blaikie (1993) describes ontology as the science or study of being and claims about what exists, what it looks like, what units make it up, and how they interact with each other. In essence, it describes our view (claims or assumptions) on the nature of reality, and specifically the question: is this an objective reality that really exists, or only a subjective reality, created in our minds? Ontology establishes the underlying assumptions and beliefs about 'the reality' and epistemology then goes on to define how we can know and reason that reality. In this research both ontological and epistemological approaches are considered relevant.

As indicated previously, the research methodology includes both qualitative and quantitative paradigms. The quantitative approach of using questionnaires in study two had ontological aspects of hypotheses, data collection from the three groups of participants (Patient, Family, and Professional). The data were analysed using one-way ANOVA to compare the means between the groups and whether any of those means were significantly different from each other. In this approach the hypotheses were tested. The researcher's stance was detached, objective, and independent from the participants. In the qualitative paradigm used in study one (focus

groups) and study three (semi-structured interviews) there were epistemological aspects with a focus on the participants and their perspectives evolving from facilitated discussions and responses to questions. In this case the variables were more complex, demanding an emphasis on interpretation and meaning and a more direct involvement in the processes.

Therefore, acquiring the knowledge required an epistemological approach that also took account of an ontological perspective, particularly as the research involves different degrees and interactions with the participants across the three studies. For example, participants' views about what occurs in their Community Forensic Mental Health world would help imply how such occurrences may be made known. The multi-pronged approach of the three studies and related qualitative and quantitative research methods was seen as applicable, as the methods used gathered data from the same world. A further reason to include more than one research method was that what was considered an appropriate method for one question may be inappropriate for another. This process of multiple research methods enabled data triangulation to be used; Easterby-Smith et al. (2002) refer to triangulation as the collecting of data over different times or from different sources. This method enabled the findings from one type of study (e.g. qualitative: focus groups) to be checked against findings derived from another (e.g. quantitative: questionnaires).

This framework underpinned the research programme. Thus choices in data collection and methodologies used in the research processes needed epistemological and ontological considerations. In line with the definitions

above (Delanty and Strydom, 2003); (Blaikie, 1993), these choices were made to minimize the potential limits of the research in basic decisions such as research questions, methodologies, data collection, method of analysis, presentation of findings, etc. The data triangulation approach provided different means by which data was created and made known to the researcher.

The data accumulated was analysed to see if relationships emerged between variables, and hypotheses were operationalized and tested, then either accepted or rejected on the basis of the evidence. From an epistemological perspective the main point was to continually improve and help validate the research results by testing, analysis, making adjustments, and then re-testing, etc.

The epistemological approach emphasises the need to secure truthfulness of knowledge (Delanty and Strydom, 2003) and to differentiate defensible belief from opinion (Brewerton and Millward, 2001). In this regard, appropriate methods were used to enable and facilitate the participants (patients, families, professionals), who were the source of knowledge in the research, to easily express their known views and thus help this researcher secure relevant findings, and furthermore to be confident in the quality and reliability of those findings. The epistemological perspective also recognised that there were justified presuppositions of knowledge as the participants were service users or providers in the areas under research. Patients and families were asked to respond in the context of their everyday experiences of the service received, and for the professionals responses were in relation to service delivery.

The structured process of the mixed-methods three-study research model (triangulation) gained knowledge from a diverse range of participant perspectives, enabled the application of the three different approaches to data collection, analysis, and findings, and facilitated comparability and reliability by using common themes across the three studies. These epistemological foundations helped frame my research design. Easterby-Smith et al. (2002) point out that having an epistemological perspective is important for it can help to clarify issues of research design and overarching structure, including the kind of evidence that is being gathered, from where, and how it is going to be interpreted.

3.5 Rationale for Study One: Focus Groups

The choice of a focus groups approach was driven by the overwhelming case for securing the views of participant groups in a manageable and reliable way. Focus groups are often used to evaluate service provision and to understand the experience of service users. "The hallmark of focus groups is the explicit use of the group interaction to produce data and insights that would be less accessible without the interaction found in a group" (Morgan, 1988, p12).

A focus group was established for each of the three categories with engagement between the participants through facilitated group discussions. The essential ethical issues can be suitably accommodated. Group interaction is encouraged as the means to explore the research issues being studied.

This approach has been adopted because it is best suited to gain the perspectives of the participant groups on the workings and services of the Community Forensic Mental Health Team. The research benefits also include the opportunity to develop ownership of the process by participants, and eliciting the key issues and their shared understandings of those issues through group discussion. It is fully appreciated that the role of the facilitator and moderator is very important. The researcher's training, qualifications, and experience in personnel management provided the group leadership and interpersonal skills necessary for successful processing of the three focus groups. An appreciation of the group dynamics contributed to a clearer analysis of the data generated.

The use of this focus group process is distinguished from individual interviews, which formed an important part of the research process at a later stage through individual semi-structured interviews and the use of questionnaires. This part of the research programme followed the focus groups as the next stage of the research.

3.6 Rationale for Study Two: Questionnaires

A key rationale for using questionnaires is that responses can be gathered in a standardised way, so they are regarded as highly objective. The questionnaires were structured on the basis of the analysis of the focus groups. The questions compiled related to themes and sub-themes that encapsulated the significant points within the participant's accounts from the focus groups.

The questionnaires were delivered through personal contact. Contacting each participant in person helped secure a better response rate than has been documented for other methods, such as communication by post, or email; this approach enabled completion in a setting of the participant's choosing. Whereas the professionals were able to complete the questionnaires unaided, patients and families were assisted by way of a 'value free' explanation of some of the questions where this was felt to be appropriate.

Once the analysis of the questionnaire had been completed, the data was used as a template for following up certain key issues that had been identified through semi-structured interviews.

3.7 Rationale for Study Three: Semi-Structured Interviews

Having completed the focus group and questionnaire studies, and following detailed analysis of the participant's views and meanings, a significant research picture was developed. Nevertheless, this also enabled gaps to be identified that could then be explored by way of semi-structured interviews.

The semi-structured interview approach was used as it affords the interviewer more flexibility than a formalized structure. This process allows new questions to be brought up during the interview and asked in different ways to get better results. It is, therefore, less constrained and more interactive; for example, supplementary questions can be tailored to help the participants better engage and respond more fully. As the interviews were undertaken with the three subject groups, it was possible to further

explore any additional thematic patterns and issues identified through this specific interview process.

3.8 Rationale for Number of Participants

The rationale for the number of participants is based on the nature of the research in terms of evaluating the effectiveness of community forensic mental health teams. Justification for participant numbers begins with the design of this research and was therefore determined by:

- The use of both qualitative and quantitative research methods – focus groups, questionnaires and semi structured interviews – and the need to secure sufficient number of participants to produce reliable and relevant data;
- The opportunity that exists for selection from those involved with the community forensic mental health teams – patients, families and professionals – which have been defined as the appropriate participant groups;
- The recruitment of sufficient numbers of patients and family members as willing participants;
- The need to secure adequate numerical participation from all of the professional groups (psychiatrists, social workers, psychologist nurses, probation officers, police officers) who are involved in the care of the patients and have contact with their families.

All those participating were assessed to ensure that they were fully relevant to the research study, so that an adequate database of information for detailed analysis could be produced.

3.9 Quality Standards

The UK Cabinet Office has produced 'Quality in Qualitative Evaluation: A Framework for Assessing Research Evidence' (August 2003, Government Chief Social Researcher's Office). It is also noted that the 'The National Research Council (2002) (US) and others (Gersten, Baker, and Lloyd 2000; Greenhalgh, 1997; Ragin, Nagel, and White, 2003) have described standards that shape scientific understanding and that are frequently used to frame the discourse relating to the quality of research. In taking account of these suggested standards, the aim will be to ensure that the quality of the research is of a high standard, including:

Transparency and Consistency of approach

The research design, methods, and processes were sufficiently transparent and consistency was applied to ensure an independent, balanced, and objective approach to the research.

Ethical Standards

The highest ethical standards were applied throughout.

Piloting

There was consistency of data collection and piloting of the research methods of focus groups, questionnaires and semi-structured interviews to test validity and make improvements before proceeding to the formal stage.

Developmental Approach

Although each sequential stage was analysed on an individual basis, inevitably each analysis determined and influenced the construction of the subsequent stage and improved those aspects of the research. This developmental research process improved the quality of the research.

Impartiality, Independence and Credibility

The researcher is also a member of the Community Forensic Mental Health Team, and hence was aware of the need to ensure that her values did not influence the research process, especially interpretation, and in that regard it was important to appreciate the concept of reflexivity – an awareness of the potential researcher's contribution to the construction of meanings during the research process (Smith, Flowers, and Larkin, 2009). The aim was to always be conscious of the importance of being meticulously impartial in the application of the research processes, not to compromise objectivity in any way, and to secure results that were reliable and that added to academic knowledge as well as having a practical application for the community forensic team.

3.10 Service user considerations applicable to all three studies

Research with offenders is a complex process requiring careful consideration, and in the case of each study there were particular ethical issues to be addressed and consents secured. The service users, also referred to as participants in the research, were selected and profiled in a way that encouraged positive engagement in the data collection, focus groups, and interviews and questionnaires, in a non-threatening process. The following were relevant considerations for all three studies:

- Ethical considerations;
- Ethical approval;
- Data protection and confidentiality;
- Securing consent;
- Selection of groups and participants;

- Criteria for inclusion and exclusion of participants;
- Data collection and analysis.

3.11 Ethical Considerations

3.11.1 Introduction

Research with offenders is not straightforward and raises many ethical questions. Offenders are a vulnerable population who are generally impoverished and disenfranchised, often subject to discrimination, and stigma (Peternelji-Taylor, 2005; Nyamathi, 1998; Roberts, 2002a). When one examines their life circumstances and characteristics, offender populations are clearly a vulnerable group. Moreover, offenders with mental illness, who were the focus of this study, experience higher rates of morbidity and mortality, particularly if they have been incarcerated in hospital or prison. It could be said then that within the offender population they are one of the most vulnerable groups. This means that ethical considerations are of the utmost importance.

3.11.2 Ethical Approval

Before the study commenced it was essential to obtain ethical approval for the research process. This approval was obtained from the two relevant bodies. Firstly, approval was sought and obtained from The Office for Research Ethics Committees, Northern Ireland. Secondly, an application for ethical approval was submitted to the Ethics Committee of the Roehampton University School of Human and Life Sciences and approved (See Appendices 1 and 2).

3.11.3 Data Protection and Confidentiality

Discussions took place with the participants who conveyed their agreement to a confidential approach ensuring that all data linked to them would be anonymous. The confidential process involved assigning numbers and pseudonyms. Agreement was also obtained to use the extracts of interviews and data in an anonymised way in this research thesis.

The transcript recordings of the focus groups, completed participants' questionnaires and details of the semi-structured interviews were retained in a locked cabinet. Access to information on computer was restricted to the researcher only, and was stored on a secure server. All the participants gave their approval to the focus groups and interviews being digitally recorded.

3.11.4 Securing Consent

Securing informed consent is considered by many to be the cornerstone of ethical research. The conduct of research with offenders is fraught with ambiguities because offenders are either a 'captive audience' that is, they are in prison or under a probation or treatment order, if in the community. This then begs the question as to whether voluntary consent is ever possible (Dennis, 1999; Moore, 1995; Verdun-Jones, Weisstub, and Arboleda-Florez, 1998). If this is the case then one has to ask the question what is the offender's motivation for participating in the research?

Ethical guidelines clearly outline the conditions in which offenders may participate in research. That is, informed consent forms signed, and no privileges or financial rewards offered. Drake (1998) indicated that

willingness to participate in her research study was considered by offenders as a way of presenting information that would demonstrate rehabilitation with an eye to returning to the community. Therefore, in this research particular attention was given to the interviews with the participants, especially offenders and their families, making sure that the consent given was understood and mutually agreed and would not impact on their treatment.

Patient participants were given an information sheet that was laid out in a user-friendly format detailing the purpose and process of the research and their involvement in it. This was explained in the interviews, and the offenders and their families gave their agreement, signed a consent form and were offered a copy for their retention; some participants took advantage of that offer. Professionals were also sent the information sheet detailing the purpose and process of the research and their involvement in it. They were followed up by telephone and/or email to respond and answer queries, and those professionals who agreed to participate signed a consent form.

In this research, it was made clear to service users that there was no obligation to take part, and that the decision by the service user would have no impact on their treatment. See Appendices 3, 4, 5, and 6 for copies of consent forms for each group.

3.11.5 Selection of Groups and Participants

All patients receiving treatment, their family members, and the professionals involved with them were considered for selection. Selection was determined

on the basis of criteria that assessed suitability for inclusion or unsuitability that warranted exclusion. Those selected provided consent to participate in all three studies, focus groups (1), questionnaires (2), and semi-structured Interviews (3).

Patient Group

Patients' whose mental health was assessed as acutely unstable at the time of this research were excluded due to the reasons of risk to their mental health. A total of thirty patients were approached, and twenty-seven agreed to participate.

The researcher ensured that all patients included had sufficient cognitive ability, literacy skills, and verbal communication capability to participate in the research programme as designed. Ability levels were already known to the researcher through existing contact with participants in the community forensic mental health team. Following this engagement they signed the consent form.

Family Members

The patients were asked to nominate a family member whom they felt most appropriate for participating in this research. Thirteen patients agreed to nominate a family member. Those nominated were either a spouse, parent, or sibling. Contact was made by the researcher in person or by telephone with each nominated person, which helped to gain trust and provided the opportunity for an explanation of the process.

Family members were invited to meet with the researcher to discuss the information sheet (which was part of the informed consent) were and given

the opportunity to have any aspect of the research clarified. This was a highly successful engagement and had the real benefit of building trust and rapport, paying dividends in the focus group and interview processes. Following this engagement the thirteen selected family members signed the consent form.

Professional Group

The inclusion criterion was based on the key principle that the professional must have active involvement in the selected patient's care, treatment and risk management programme. The approach to these identified professionals followed a similar process to the other participants, involving the provision of the information sheet and follow-up telephone and personal contact to clarify any issues on their part. Fifty-seven professionals in total were contacted, with eighteen responding to contact and agreeing to participate in the research study.

3.12 Data Collection and Analysis

Overall Procedure

The procedure involved multiple methods for data gathering, including focus groups, semi-structured interviews, and questionnaires with patients, families, and professionals engaged with the CFMHT in the Southern Health and Social Care Trust area. The rationale for the procedure has been set out in Chapter 1. In particular, thematic analysis was used to identify and code meanings present in the data and to identify recurring themes. This procedure established the basis for collection of data and facilitated an in-depth analysis.

Settings - Location

Care was taken to ensure that the settings for data collection were non-threatening and best suited to securing good quality data. In the case of patient and family participants, consultation took place and agreement was reached to secure their approval of the settings. In most cases this was the office environment and for others the mutually-determined preference was the participant's family home. Where this setting was agreed, the researcher was satisfied that the home environment was suitable. For the professionals, the data collection took place in an office environment.

During the semi-structured interviews, where safety was deemed to be a risk with some patients, arrangements were made for an acceptable professional person to be present with the researcher.

Mixed-Methods – Analysis

The methods used were both qualitative and quantitative as described in the rationale section in Chapter 1. The data were analysed using thematic analysis techniques for the qualitative data (semi-structured interviews and focus groups) and SPSS statistical analysis of variance for the quantitative data (questionnaires).

3.13 Applications of Results: Academic and Practical

A central part of the discussion and assessment of the research results was a determination of both their academic and practical application. An important consideration was the extent to which the findings from the participants through the sequential stages of the research made an original contribution to academic knowledge. Another consideration was the extent

to which key findings could be used in practical terms to improve the therapeutic service for the benefit of patients. The research was expected to add to or challenge the current models, or perhaps lead to the development of a new model in offender rehabilitation.

3.14 Role of the Researcher

In undertaking the research it was necessary to be aware of the role of the researcher and the power dynamics at play, particularly in the qualitative approaches of focus groups (study one) and semi-structured interviews (study three). In the briefings and discussions of the methodology and processes involved it was made clear to the participants that the researcher would assume a moderator role to help participants freely express their opinions. Thus participants and the researcher were 'operating under the shared assumption that the purpose of the discussion is to display opinions to the moderator' (Myers 1998: 85).

A number of key issues arise for the researcher in what is a complex relationship with the participants. The qualitative research undertaken was an interactive process in which the participants talked about their life experiences. The researcher as a consultant forensic psychologist knew the participants, and in the case of the patients there existed a therapeutic alliance. Therefore, power dynamics was an important issue. The researcher was critically aware that the participant's actual or perceived views of the researcher's attributes could affect focus group behaviour and discussions, and because participants' characteristics were known to the researcher, this could also impact on the role of the researcher. The same

research risks would also exist in the process of conducting the semi-structured interviews. It could be argued that this potential for bias would diminish the validity of the discussions and engagements and thus affect the findings. However, the therapeutic alliance turned out to be a benefit; there was mutual appreciation of the research context and an acceptance of freedom of expression by the participants, who accepted from the professional participant experience that the researcher was non-judgemental and supportive. This same experience enabled the researcher to be more alert to the truthfulness – or otherwise – of opinions. This minimized the risk of a disruptive occurrence of power dynamics. Nevertheless, the moderating role exercised by the researcher was still required, to ensure that there was no 'sameness' between the moderator and the researched. To overcome this possibility the researcher brought up relevant topics for the research, but the direction of the conversation depended on the issue as perceived by the group. There was minimal intervention unless it was felt that the group was being side-tracked by topic runaway or by a dominant voice.

Effective conversational participation by all the focus group members generally occurred, but occasionally the researcher, in a moderating role, had to intervene. For example, silence is an 'enduring feature of human interaction', present as much in research communicative contexts as elsewhere (Poland and Pederson 1998: 308). The researcher intervened occasionally to prompt discussion and encourage silent or quieter participants to speak within the group. The researcher sought to keep the discussion at the level of everyday talk and not, for example, drift into 'focus

group' or language that was too professional. For the researcher to communicate in a professional manner would convey a message of control and power to the participants, affect the quality of the messages, and ultimately the results.

Throughout, the researcher was conscious of avoiding bias; what was important was the participant's values and beliefs about an issue or situation, and not the researcher's opinion. The same researcher role was applied in the semi-structured interviews where participants and the researcher's interactions and dynamics also tapped a wide variety of opinions, albeit in a different form of interaction. In the semi-structured interviews there was a one-to-one engagement, and the opportunity for a more direct observational perspective in receiving the responses to the open-ended prepared questions that had been influenced by findings in study one and study two. Participant observations such as eye contact, body language, and tone of voice aided the analysis in both the qualitative approaches (study one and study three). In the quantitative approach in study two, which used questionnaires to identify statistical relationships, objectivity was critical. In the case of the qualitative approaches, subjectivity was expected and the research sets out the participant's perspectives.

Critical awareness of the researcher's role facilitated exploration of views so that they were recorded and analysed as far as possible to truly reflect the participant's experiences. This also helped to manage the power dynamics of the therapeutic alliance of the professional-patient relationship and the researcher's presence.

CHAPTER 4: STUDY ONE

THE RELEVANCE OF REHABILITATION MODELS; THE VIEW OF PATIENTS, FAMILIES, AND PROFESSIONAL GROUPS

4.1 Introduction

This chapter outlines the relevance of offender rehabilitation models from the perspective of patients (with forensic needs), families, and professionals. In this study the primary aim was to consider the relevance of rehabilitative models ('What Works', 'Risk-Need-Responsivity', and 'Good Lives') from the perspective of patients, their families, and professionals. In doing so it was hoped that a detailed insight into the beliefs and experiences of the participants would be obtained.

Some of the results have been included in this chapter in tabular format and others set out as Appendices. Where appropriate, the views and experiences of the participants have been included to help illuminate the results and the analysis of the data. The results process and the analysis were grounded in the aims and objectives.

The aims and objectives for study one included:

Aim: To identify empirically-based rehabilitative models that patients, families and professionals perceive as relevant and beneficial in a forensic patient's treatment and risk management plan.

The 'What Works' model (McGuire, 2000) suggests that, in general, community-based treatment programmes produce more positive results. This is also indicated in the 'Good Lives' model (Ward, 2002), which

provides a framework for working positively with forensic patients in the community. For example, reintegrating a person into the community and increasing their access to a healthy social life can positively impact on their mental health. Furthermore, the 'Risk-Need-Responsivity' model (Andrews and Bonta, 1994) emphasises the importance of being 'responsive' to the needs of an offender, and also that treatment interventions should be delivered in a way that is meaningful and makes sense. So, for example, tailoring interventions to the needs of offenders who have mental health problems, and who live in the community. The Reed Framework (1992) proposed a number of core values and principles that CFMHTs should uphold, one of which states that treatment should be in the community as far as possible, rather than in institutional settings, and should be delivered in such a way as to maximise rehabilitation, thus increasing the patient's chance of sustaining an independent life.

Aim: To explore satisfaction and the attitudes of patients, families, and professionals towards the community forensic mental health service.

Aim: To explore the therapeutic alliance between patients, families, and professionals within the community forensic mental health service.

The perspective of patients, families, and professionals with regard to rehabilitative models is under-researched. One of the aims of study one is to obtain the views of service users in this regard. Research suggests that service user groups have valuable opinions to contribute concerning the treatment and rehabilitation of forensic patients. The Sainsbury Centre's research (2001) indicated that mental health service users not only have

something valid to say about the services they receive, but also that by contributing their self-esteem and confidence improves.

Dijk et al. (2003) considered it important to assess the priorities that patients have with regard to different aspects of their care. In their study they used the data-collection methods of focus groups and interviews, which in themselves were a positive process for the patients to engage in. However, measuring patient satisfaction can be difficult (Dijk et al. 2003) as it is often not clear what patients actually mean when they say they are satisfied with a particular aspect of their treatment. The Irish Study for Quality and Safety in Health Care, Measurement of Patient Satisfaction Guidelines (2003), identified the need for a national standardised approach to the measurement of patient satisfaction. Gerber and Price (1999) measured the satisfaction of seriously mentally ill patients within an assertive community treatment programme in Ontario, Canada. Key findings from this study included that patients would like to spend more time with their key worker. Overall, studies suggest that users with a history of severe disorders can be involved in evaluations of services as well as the services themselves. This may depend on adequate support; all of the studies referenced included details of the support that was provided to service users. The service providers gave practical and personal support to users; for example, discussing issues of confidentiality and participating in focus groups.

The overall aim of study one is to produce a rich set of qualitative data from the perspective of patients, families, and professionals that evaluates the relevance and importance of rehabilitative models in the treatment of forensic patients. A secondary aim of study one is to explore how satisfied

services users are with the current service provided to forensic patients in the community, and the degree of therapeutic alliance experienced. It will also be interesting to compare and draw out differences in the three service user group perspectives.

4.2 Methodology

Developing the focus groups and questions

The main reference point for developing the focus groups was the psychological rehabilitative models and stated hypotheses for the research (see Chapter 1 Introduction). Therefore, the development of questions for the focus groups were informed by examining in detail the three models at the core of the research, namely; 'What Works' (McGuire, 1995), 'Good Lives' model (Ward, 2002), and 'Risk-Need-Responsivity' (Andrews and Bonta, 1994). A set of open-ended questions were constructed around these models to promote discussion (see transcript extracts in section 4.3 and topic guidelines in Appendix 7). The open-ended nature of the questions created the space for participants to freely express their opinions, and thus produced a rich set of data. The questions were designed to generate a range of perspectives from the three participant groups on the relevance of the rehabilitative models for each of them in the context of a forensic community mental health service.

Conducting the Process

a) Pilot Group

A pilot focus group was established with patient participants to test the questions. A key requirement was to ensure that the questions were user-friendly and that they were clearly understood by all groups. This was

particularly relevant with the patient group because of their potentially-lesser cognitive abilities. The pilot group was composed of six participants of different ages, with a range of mental health diagnoses and offending backgrounds.

From the pilot exercise a number of modest changes were made. This included adding an 'introductory question' to help initiate conversation. A concluding question was also added to allow participants to express a particular view that was not covered by the set questions. In addition, a number of questions were merged thus reducing the overall number. This helped to strengthen the coherence of the process and its relevance to the participants. The Topic Guidelines Schedule for the Focus Groups is set out in Appendix 7.

b) The Focus Group Procedure

Having successfully completed the pilot, the next stage was to undertake the formal research work with the three participant focus groups: patients, family members, and professionals. These were completed sequentially with the first being the patient group, followed by family and professional groups, in the mutually-agreed setting of the researcher's office base. All the discussions of the focus groups were digitally recorded and supported by hand-written notes. In the case of each focus group, before the process commenced, the participant's understanding of the research was assessed. The need for transparency, honesty, openness, and to respect differing opinions that emerged from the discussions was emphasised and accepted by the participants.

The digitally-recorded notes were transcribed for each focus group and supplemented by hand-written notes. All participants expressed contentment with the focus group procedure. Participants in each focus group were asked the same questions under the generic themes of:

- Satisfaction with the service provided by the community forensic mental health team;
- Perceived benefits of the community forensic mental health service for patients and their families;
- The range of service provision by the Community Forensic Mental Health Team;
- Service users' needs being met;
- Understanding of risk assessment and risk of offending;
- Understanding of the benefits of group therapy (Good Thinking Skills Group) for service users;
- Perceived impact of the service on re-offending;
- Perceived impact of the service on mental health stability;
- Engagement with service user's family/carer;
- Engagement with professionals who make referrals into the service;
- Reintegration of service users into the community.

The questions in the focus group were in sequence from broad or general to narrow or specific, as suggested by Eliot and Associates (2007):

- *Engagement questions:* begin the session with a question or two that put the participants at ease and create a comfortable environment open to participation;

- *Exploration questions*: penetrating, well-constructed group members' questions that get to the heart of the discussion;
- *Exit questions*: ask if there is anything more or any further comments regarding the topic, and check if we had missed anything.

Subject Group Profiles

Each of the three subject groups were heterogeneous and their profiles are detailed in the following tables.

Table 1: Patient Group

Gender	Diagnosis	Age Range	Offence
Male	Personality Disorder	22	Sex Offending
Male	Paranoid Schizophrenia	25	Violence
Male	Paranoid Schizophrenia	39	Violence
Male	Paranoid Schizophrenia	36	Violence

Mean age: 30

Table 2: Family Member Group

Gender	Relationship to Patient	Age Range
Female	Mother	61-70
Male	Father	69-70
Female	Wife	32-40
Female	Wife	31-40

Mean age: 48

Table 3: Professional Group

Gender	Profession	Age Range
Female	PSNI Sergeant	41
Male	Manager of Probation Hostel	56
Male	Manager of Residential Housing	52
Female	Discharge Liaison Nurse NIPS	43-50
Female	Discharge Liaison Nurse NIPS	43-50

Mean age: 47

4.3 Analysis of Results

The analysis of the results started with in-depth consideration of all of the transcribed data using the thematic analysis approach. Thematic analysis was selected as a way of interpreting the qualitative data: 'Most researchers consider thematic analysis to be a very useful method in capturing the intricacies of meaning within a data set' (Guest, 2012). It provides for the development of themes, which are a critical framework for this research.

In order to minimise the potential bias in analysing and interpreting focus group data, Krueger and Casey (2000) point out that the analysis should be systematic, sequential, verifiable, and continuous. To secure reliability a framework analysis was developed, which, as described by Ritchie and Spencer (1994), is 'an analytical process which involves a number of distinct though highly interconnected stages'; in this study it included familiarisation;

identifying a thematic framework; coding or indexing; mapping, and interpretation. A distinctive aspect of the framework analysis is that although it uses a thematic approach, it allows themes to develop both from the research questions and from the narratives of research participants (Rabiee, 2004). This was relevant in the approach adopted.

The analysis of the results started with an in-depth consideration of all of the transcribed data using this thematic analysis approach. The three sets of transcribed data (patient, family, and professional) were reviewed to provide an overall perspective of the whole data. The next step was to undertake an in-depth analysis of the data from each focus group. The first to be completed was the patient group, followed by the family group, and finally the professional group. The analysis process incorporated a number of phases (Clarke and Braun, 2006), as follows:

Phase One: Familiarisation

To assist with familiarisation of the data it was read and re-read several times paying particular attention to reoccurring patterns and meanings. The recordings were listened to in their entirety, and the observational notes were reviewed. The researcher's questions and interventions were considered an important part of the familiarisation and provided an analytical context. This immersion in the detail generated a real sense of the focus group interviews as a whole. Even at this stage thematic ideas began to emerge. The next stage was to break the interviews into parts and to more thoroughly interrogate the data.

Phase Two: Coding

This phase involved identifying a thematic framework, by writing first thoughts, meaning, and interpretative notes in the margin of the transcripts, highlighting salient comments and referring to researcher notes. This framework helped shape the coding/index exercise. A preliminary list of ideas about what was in the data and what was interesting in terms of the research was developed. From this approach a system of colour coding was created by writing key repeated expressions using a process of data reduction on flip-chart sheets. This involved a sifting of the data, highlighting and sorting out quotes, and making comparisons both within and between participants. It also involved re-arranging the quotes into harmonious groupings for further consideration. The data was then coded into descriptive groups. From this process a series of initial categories were developed. The aims, objectives, and rehabilitative models were frequently referred back to, to keep the analysis on track.

Phase Three: Interpretation

The data was now ready for the final stage of analysis, i.e. interpreting and mapping. It was important to keep revisiting the original data when interpreting the initial categories and the related quotes. At the same time the interpretation required an awareness of the relationship between the categories (and quotes), and the links between the data as a whole.

As a first step, the data in each flip chart sheet were assessed to ensure there were no information gaps. Some inferences were made about what the colour codes may mean in terms of interpreting the categorisation into

potential themes. Krueger (1994) provides seven established criteria, which suggest the following headings as a framework for interpreting coded data: words; context; internal consistency; frequency and extensiveness of comments; specificity of comments; intensity of comments; big ideas. This was done by further collating data under the emerging themes in an evolving process of inclusion and exclusion until the right home for data was found in a theme. The theme categories were then compared with each other and grouped into larger themes. It was important to assess any inconsistencies or tensions between data patterns.

The following extracts taken from the transcripts of the three focus groups provide some examples of the process. Key phrases are highlighted and the researcher's initial observations, comments, categorization, and potential themes are included. The facilitator contribution by way of question and guidance to the participants is shown in bold type.

Patient Focus Group Transcript

Several areas from the extracts were removed and words deleted to protect anonymity.

Transcript: sifting, highlighting, - key words and phrases, etc.	Notes; meanings, categories, themes
<p>So just going to start off with, what do you think are the major issues presenting you at the moment?</p> <p>M: What do you mean like?</p> <p>Well you've received the service from the forensic team, okay, what do you think are the major things that maybe you need help with from the forensic service?</p> <p>M: Oh right, motivation.</p> <p>Motivation, and is there any particular things that you need motivation in?</p>	<p><i>Early pointer to treatment issue</i></p>

<p>M: To get out and do stuff like.</p> <p>So kind of like daily activities really?</p> <p>M: Yeah.</p> <p>So from when you get up in the morning to.</p> <p>M: To help the wife around the house and all that.</p> <p>So the first one is - some people say that people that are at a higher risk of getting into trouble, say with the police etc.,, should receive longer or more intensive or more in-depth treatment from forensic services, what do you think of that?</p> <p>M: I think everyone should get as much help as they need really. It shouldn't be specific to people who are at risk of getting in trouble with the police.</p> <p>So that's interesting. So you're saying that it shouldn't really be dependent on risk level necessarily; it should be more about the individual?</p> <p>M: Yeah, the individual need to help people to get better as quickly as possible rather than. I mean you should have, obviously, help people with offending behaviour but you should get the same standard of help. Everyone should get as high a standard of help as.</p> <p>Regardless of what risk that person is.</p> <p>M: Yeah.</p> <p>M: may not (unclear) be their fault like. You know, they ... illegal to go out and do these things like, you know, because of mental health issues [unclear] maybe they should get more in-depth help.</p> <p>So you're saying maybe there should be a bit more intensity and maybe lengths of treatment.</p> <p>M: Aye, and if they did get in trouble with the police like, you know, something should be set up like, do you know what I mean, sort of explain to the cops that they're, you know, they're not wild like.</p> <p>So maybe in addition to that maybe a greater awareness or communication to the police about why</p>	<p><i>Helps stabilise family life?</i></p> <p><i>Outcome – responsivity?</i></p> <p><i>Equality, Fairness in treatment interventions</i></p> <p><i>Risk assessment treatment (Theme?)</i></p> <p><i>(One opinion?)</i></p> <p><i>Wellbeing - important factor</i></p> <p><i>Risk management</i></p> <p><i>Support?</i></p> <p><i>Communication, Collaboration, Team working across professions including Police (further opinions on standards – treatment intervention) (summarised)</i></p>
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<p>the person has behaved in the way they have, yeah okay.</p> <p>M: some [unclear] people that aren't at risk of getting should get the same standard as people that are at risk of offending.</p> <p>Okay, so that's about, it's maybe not about the length of treatment but the quality of the treatment you're saying, yeah, so regardless of risk.</p> <p>M: Everyone should be entitled to the same high quality, rather than just giving high quality to the people at risk of offending. It seems a bit unfair on the others.</p> <p>Forensic services target both general life problemsSo do you think it's important that it looks at social side, physical?</p> <p>M: It's all part of the same, you have to improve all aspects of life [unclear] offending, you can't just look at one area.</p> <p>So you feel that they all kind of come together and sort of influence each other.</p> <p>M: Yeah.</p> <p>M: You do need more help with social side [unclear]. It's just if you can get support before you go into the crisis, you've got that to hold onto. From say the forensic teams or whatever, whatever you learn from that, you can hold onto that.</p> <p>That's a really good pointthe service being proactive and working with you on all those kind of social needs and physical needs, and you're saying that that will prevent maybe offending behaviour....</p> <p>M: Well you can't just tackle offending behaviour if you don't improve the other aspects of the life, because it doesn't really work if you just focus on one area.</p> <p>How important is where you receive your treatment from ourselves to you?</p> <p>M: I would say yes [unclear]. I don't like going to the hospital</p>	<p><i>Quality issue! Role of worker – are they delivering quality? Governance? Resources to do this?</i></p> <p><i>(Follow up in study 2, 3)</i></p> <p><i>Wellbeing – holistic approach</i></p> <p><i>Emphasis on social aspects</i></p> <p><i>'Whole life' Treatment intervention has a responsivity (summarised)</i></p> <p><i>Recognition – insight!</i></p> <p><i>Hospital is chill factor?</i></p> <p><i>Location an issue?</i></p>
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<p>M: It's just like as if, in a way it's a hospital bed in there, when it comes to home time, just comfortable going home ...[unclear].</p> <p>So the thought of going to hospital, you don't really like the thought of it, but once you get there you see the benefit of being there.</p> <p>M: it's difficult to explain properly you know. You don't want to be there [unclear].</p> <p>M: I suppose home's different [unclear].</p> <p>So I guess what you're saying there is that you're prepared to go to wherever you're going to get the best kind of treatment for you....</p> <p>M: Yeah.</p> <p>M: I do find it's useful to get some appointments at home, but then also some at, you have to go to again ...[unclear], it's just you can get them coming to the house, you know you have to have the house in a reasonable condition and stuff</p> <p>M: No, but it's sort of.</p> <p>[Talking together]</p> <p>M: It's a motivating factor.</p> <p>M: Make the effort.</p> <p>It's kind of going back to that meeting other needs, rather than the actual offending needs sort of side of it isn't it?</p> <p>M: Yeah.</p> <p>It kind of motivates you to get yourself in order, and get your house in order and that kind of thing.</p> <p>M: Yeah. But then you'd maybe have to go to appointment at the health centre, whatever, generally you know what time it's going to be at.</p> <p>M: You know, going to the home with traffic conditions and stuff could mean that it's a little.</p> <p>It's more structured</p> <p>M: Yes, it's a little more unpredictable with the home visits.</p>	<p><i>(Living environment)</i></p> <p><i>Home is best on occasions for treatment intervention-issue?</i></p> <p><i>Better Responsivity?</i></p> <p><i>(Responsivity a theme?)</i></p> <p><i>Structure</i></p> <p><i>Home location</i></p> <p><i>(Needed to move conversation on-facilitate)</i></p> <p><i>Both home and office/centre are preferred</i></p>
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<p>So would you see that as a key benefit then for yourself to appointments in an office is that you know exactly when it's going to happen, the day and the time?</p> <p>M: Yeah.</p> <p>So any other benefit that you see in it?</p> <p>M: I'm not sure really, sort of I think a mixture of both. You know, I don't think you should have exclusively one or the other, just a mixture of both means. If you know you have like certain appointments at certain times each month or whatever at the office, then you get your home visits in between, you know, it's a bit more structured and.</p> <p>Do you feel you respond in a different way when you're seen in those different environments? So when you're seen at home do you feel you respond in a different way to say for example if you're coming in here to see one of us?</p> <p>M: I'm not really sure [Unclear]. It's just, you know, [unclear] coming out to the house, and you've seen me in a bad way, you know, and if I had come into like somewhere, I probably would've had hated it. Because I had at home, you know, nobody could stop me from getting that episode out, you know, that way and you're able to see that. You had a sort of outlet. But ...that's only me personally.</p> <p>Interesting point and I'm glad you raised it. So when you're at home ... we get to see the real you in a way because it's your environment...</p> <p>M: It's masked maybe, some sort of.</p> <p>M: You know, I don't want to hold up things up, but feel comfortable to say whatever you want to say you know, don't want to hear things, criticisms or whatever. You know, this is the place to put the things out, and that's a very good point (name), you know.</p> <p>Do you prefer kind of individual work with a key worker... one-to-one work, or do you like coming to groups... what is your preferred method or do you like</p>	<p><i>Living environment is emerging as an issue – home is good for treatment visits</i></p> <p><i>(Theme?)</i></p> <p><i>Confident statement!!</i> <i>Difficult to interpret – means- at home I can cope best when I have an 'episode' (ill)</i></p> <p><i>So assessment and treatment intervention better and responsivity?</i></p> <p><i>Dangers of Masking</i></p> <p><i>Encouraging!</i></p> <p><i>Key worker</i> <i>Groups social outlet- interesting!</i></p>
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<p>a combination of those kind of things, what do you think?</p> <p>M: I find groups very good for tackling general problems, and they give a social outlet as well. Then you need the individual work as well for more personal things that aren't just general. So like I think both.</p> <p>Do you like things given to you in written form, how do you feel about that, or you prefer us talking to you,</p> <p>M: I suppose it depends how you feel on the day, you know, whether you're going through a bad patch or whatever, as opposed to reading it.</p> <p>M: I think it depends on the information. Sometimes it's useful to have it written down and then if you have any questions you can ask them. You take the time to read over it and then ask any questions you might have. I do like quite detailed information personally.</p> <p>How you feel we work with other services... our service and say for example your psychiatrist, your social worker if you have one and you're GP?</p> <p>M: I think it is shared very well. I do find with the general psychiatrists who are lot more like (likely) listen to forensic services a lot more than the generic services; they take on-board what they say a lot more. So I do find it is quite useful in forensic services for information sharing</p> <p>M: Mental health's a lot better now than, since you came on board with forensic services than it was any time before then, so I think it has been very beneficial for me.</p> <p>Can you think of any reasons why that might be, is there anything that we have done differently?</p> <p>M: Well you have to be a lot more involved and helped me learn a lot more about my illness than what I knew previously, and I've learned new techniques for dealing with the illness and stuff. Before I was with forensic services I knew very little.</p> <p>What do you see then as the key benefits of the community forensic mental health team?</p>	<p><i>Mood</i></p> <p><i>Professional approach</i></p> <p><i>Detail and layout- each patient different-communication</i></p> <p><i>Not a big issue</i></p> <p><i>Comparisons</i></p> <p><i>Collaboration point – perception or reality?</i></p> <p><i>Positive perspective</i></p> <p><i>Indicates importance of therapeutic alliance</i></p> <p><i>Nice to hear – patient looked sincere and expressed with meaning</i></p> <p><i>Explore key worker role further</i></p>
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<p>M: You know what to watch out for. I suppose (key worker name) would probably be ...[unclear] it would be a sign then that things were starting to ...[unclear].</p> <p>M: I do feel we get a much higher standard of care in the forensic team than you do from the generic team, and you do have a lot more contact with the forensic team, so they can pick up new problems much quicker. And (name) is very good at dealing with problems too</p> <p>M: Maybe could do with a few more staff; I find it difficult to get through on the phone sometimes, you know.</p> <p>M: Yeah, well there used to be. I mean when I first came into forensic services there was two nurses, not always at the same time but, you know, but now there's only the one so it's sort of. If there's any, when there was two if there was a problem came up one of them could deal with it and you'd still get seen. But now there's only one....</p> <p>We would do individual work and we'd run groups, the good thinking skills, what do you prefer, do you prefer individual work, do you prefer group or do you like a combination of both of them?</p> <p>M: A combination of both of them. The way it was in [...], the whole group together, and then we split up into parts and done our questionnaires and stuff like that. That was a good idea. You get to know people [unclear]. It has been good.</p> <p>What about your family members, what do they think of the service you receive, have they any opinions on it?</p> <p>M: Well my family are quite happy with the way things have gone.</p> <p>M: I would say they're happy.</p> <p>Think of the service you receive, do they feel it could be improved upon, have they seen a change in you since you have been with forensics?</p> <p>M: They've probably seen a big change in me like, you know, from living at home. Well I think ... [unclear] uptight about is not getting much calls to the house. But everything's good.</p>	<p><i>Resources – governance (Theme?)</i></p> <p><i>Check if resources-governance is an issue with professionals – (Theme?)</i></p> <p><i>Treatment interventions- both- explore further? (Theme?)</i></p> <p><i>Check with family focus group</i></p> <p><i>What works- check out in studies 2, 3?</i></p>
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<p>M: ...[unclear] and mental health part of it, that health part of it is, well I know why I was like, you know, going back to the state I was in, you know. I have a clear head now from what I had. I'd been in hospital for 15 years you know.</p> <p>So it has improved your mental health then.</p> <p>M: It has surely yeah.</p> <p>If someone came to you and said right you can have whatever you want in the forensic service, what would it be?</p> <p>M: At the minute, there's very little social activities in my area that are suitable for someone my age and with my past.</p> <p>M: Yeah.</p> <p>M: Because there's virtually nothing that I'm aware of in the entire Southern Health Trust that's really appropriate for me.</p> <p>M: Yeah.</p> <p>M: I go to some ...[unclear] in the gym, and ...[unclear] I'd say you got half price, do you know what I mean, for your illness you know what I mean, and like ...[unclear] transport and the bus you know what I mean as well.</p>	<p><i>Social outlet is big issue- raises the question of sigma</i></p> <p><i>Public perceptions?– Afraid to go out freely to any social place</i></p> <p><i>Socially – restricted? Does this relate to NI culture? Themes?</i></p>
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Family Focus Group Transcript

Several areas from the extracts were removed and words (names) deleted to protect anonymity.

Transcript: sifting, highlighting, - key words and phrases, etc.	Notes; meanings, categories, themes
<p>The first question overall looking back on those years, do you think it's (the Service) been of benefit?</p> <p>F. I think it helped him (patient) to realise that he just can't do what he wants, that he had to step back and think about what he was going to do.</p> <p>F. The continuity of care has been very beneficial, both for me and for the children, because they know key worker</p>	<p><i>Thinking skills – output from treatment (theme)</i></p> <p><i>Key worker role – critical (explore in questionnaire).</i></p>

<p>now just as a face coming into the house. You know, that's been very important..... it's not (Key worker) the nurse or, you know, it's just A (key worker's name).... I think it's personality as well...source of support for me and B (patient)... source of support to me when he's in hospital....he rang me several nights to see how things were going, to see how I was coping.</p> <p>So one of the key things that I'm hearing then is the support, and you were saying about specific care interventions that you've found helpful as beneficial, and also just the human touch as well</p> <p>M....some people doesn't need long term care, others do, and he (patient) said I think there's [a tag?] on at the minute and he was able to attend there every week.... one stage we were told we were losing him but that hasn't happened.</p> <p>F: It's very good, because they do need to get used to that one consultant.</p> <p>We just want to make sure that as a team we're doing that we're not just focusing on the things that you did wrong, but we're looking at all the positive things that you can do in your life as well. So do you think that's something that we do?</p> <p>F: Yes, and he loves coming to your courses, and to go on to A, but the like of B and - what do you call that other place around here?</p> <p>M: C.(name of service and location)</p> <p>F: C - right, he doesn't like those places. He just, we can't get him to go to them at all, and really I can understand, you go in and there's maybe somebody sleeping beside him, and there's not a lot going on.</p> <p>F: You've got a point there.</p> <p>F: We can get him more activities and all ourselves than what he's getting there.</p> <p>F: he went once and he wouldn't go back because it was full of older people and they were just drinking tea</p>	<p><i>Therapeutic alliance</i></p> <p><i>(Professional Characteristics-Theme)</i></p> <p><i>Family support – explore more (Theme?)</i></p> <p><i>Summarised</i></p> <p><i>Treatment appreciation</i></p> <p><i>Discussion between participants points to treatment interventions (theme)</i></p> <p><i>User satisfaction</i></p> <p><i>Opinion – resistance responsivity (theme)</i></p> <p><i>Family need to be involved? (Theme) (good interchange of views)</i></p> <p><i>Need for treatments assessment to be</i></p>
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<p>F: It's certainly changed now.</p> <p>F: Has it?</p> <p>F: A goes to that so he does, and it is, they're definitely starting to take more of a viewpoint of the younger ones.</p> <p>F: Oh that's good.</p> <p>F: I think now the bigger centres are great, there's a great source, when it's done right. When you go in and you see them sort of sitting about drinking tea and then not really doing it, there's no benefit in it.</p> <p>[Talking together]</p> <p>F: I think it's very hard for anybody with mental health to sort of take that bite and keep going to it.</p> <p>F...treat them like an adult....part of his thing would be strangers as you say, so that it takes a lot for them, you know what I mean, to take that big step and to continue going places, you know</p> <p>When you're running a group for the first time it is very daunting for somebody to go into a strange environment and meet people.</p> <p>F: Well even the way today, even coming in here today, I mean obviously I knew you but I didn't know any of the rest of you. And it is until I started, but you go on because I mean mentally you're fine. But from someone that is very unwell, I mean it must be just very, very frightening.</p> <p>F: There's a great advert on the TV at the moment about mental health.....there is that fear that people don't know what to say.</p> <p>F:...sort of looking at him like that, you know, nearly as if he's going to jump on or attack them or something, you know, and I find that offensive.</p> <p>F:....probably in another maybe five to 10 years mental illness will be looked upon as the flu or, you know what I mean, it will be just accepted., You know, there'll not be such a fear.</p> <p>How important is it where your family members receives their treatment?</p>	<p><i>right, interventions right and family feedback taken into account</i></p> <p><i>(Family involvement theme)</i></p> <p><i>Psychological wellbeing an issue facing real world</i></p> <p><i>Anxious – but wants to share!!!</i></p> <p><i>Fear</i></p> <p><i>Stigma introduced?</i></p> <p><i>Stigma!</i></p> <p><i>Public perception!</i></p> <p><i>Awareness – explore further?</i></p> <p><i>(Theme) Education – public</i></p>
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<p>F...I do face a daily struggle when A is in hospital. I mean you're juggling family, you're running a house, you're running down every night to see A , you're cooking food...</p> <p>F: You have to be honest and tell ...[unclear] or the consultant, you have to, you can't hide anything.</p> <p>So it's good that people do come out to the home environment then, because it's more real I suppose.</p> <p>F: Definitely, I mean they see sort of where you're coming from, who they exactly are, definitely it is yeah.</p> <p>Do you feel that information is shared well between different agencies, is that okay, you're shaking your head?</p> <p>F...I should have been told he's being moved because of A, B or C, and this is Dr A and this is who's going to be dealing with him on Ward? Whereas I find, I was nearly sort of moving between two different countries if you like, do you know what I mean?</p> <p>F....before he went in the hospital. Then the whole thing with Social Services, and then the way they sort of portrayed it to them was, you know, A is definitely, you know, he's a danger, but yet five days later.</p> <p>F: I find that unbelievable.</p> <p>F: Go on ahead like, just get on with it.</p> <p>F: I could tell you a big long story about that, but I'm not going to. But can I just ask you something, what is the concept behind D (treatment centre)? He can't get in but they can walk out, actually I'm not sure what the concept is.</p> <p>He can't get in, do you mean...?</p> <p>F: He can't get in but they can walk out. Last year he was very sick when he was moved, and he got out on them three times, on this time when A (Key worker) said he's going back to C (hospital treatment centre), I said no he's not.</p> <p>F: They can walk out. You can literally walk out</p>	<p><i>Family pressures – hospital is difficult</i></p> <p><i>home is better (living environment –theme)</i></p> <p><i>Communication, involvement issue</i></p> <p><i>Poor Collaboration between services?</i></p> <p><i>Good insight into service user family perspective – check out</i></p> <p><i>Professional collaboration</i></p> <p><i>Big statement!</i></p> <p><i>Risk management issue!!(theme)</i></p> <p><i>What makes a good professional? (Characteristics) Key Worker issue</i></p>
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<p>We've talked about a lot of the good stuff in terms of benefits that are going on, but the community forensic team, what sort of things do you think could be improved upon?</p> <p>F...The communication line's always open with him (staff), I can phone him again, so I mean I would have to give you the thumbs up.</p> <p>F: I think there ought to be guidelines and somebody probably to sit down and say right we'll think about this, if I were a person who had a mentally ill relative and they were in real trouble, you know what I mean, how could I sort of make it very easy for them to assess, you know, a mental health professional, get them seen, get them into hospital quicker, you know.....</p> <p>F...This is another point, I suppose nothing to do with your services but he's being sent home for an overnight stay tonight, and I have to bring him back down for 10 o'clock in the morning to be discharged.....</p> <p>F: At the end of the day they're very sick, but you're their wife there, you know what I mean, there's that relationship there, you can't sort of say no, you know, you're sick I have to take a break. You can't, because emotionally you have to go and see them yourself, you know.I</p> <p>If someone would say forensic service we're going to give you so much extra (money), how do you think that should be used?</p> <p>F....More courses, definitely. More research possibly into why they offend, or is it something, you know, is it the illness? Well obviously it is the illness but definitely more sort of services that say the likes of me, even, you know what I mean, more sort of family things. Because I think to a degree they're mentally ill, you live with it, you've got an insight into it....You know, I think probably if there were more groups like this for families to include them as well, then they mightn't see it as us and them.</p> <p>That's a really interesting point.</p>	<p><i>Structured approach</i></p> <p><i>Communication</i></p> <p><i>Assessment – family involvement (Recurring theme)</i></p> <p><i>Reality!!! Family support a big issue (theme)</i></p> <p><i>More courses; research; more relevant services – groups supported</i></p>
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<p>F: What about like a support group for carers to deal with the forensic?</p> <p>F: Oh yeah definitely, well I mean it was good for me meeting yourselves today and listening to A (family participant), I was thinking thank god I'm not the only one. [Talking together]</p> <p>F: We're different, we can share, we have each other.</p> <p>F: The family is so important.</p> <p>F: Oh god yeah.</p> <p>F: Did your partners ever not want to live, did they ever?</p> <p>F: Talks all the time that he doesn't want to live</p>	<p><i>Groups</i></p> <p><i>Family involvement and support (theme)</i></p> <p><i>Focus group ends with discussion on suicide and very personal comments- All emphasising the need for support for families of these patients!!!!</i></p>
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Professional (Forensic Staff) Focus Group Transcript

Several areas from the extracts were removed and words (names) deleted to protect anonymity.

Transcript: sifting, highlighting, - key words and phrases, etc.	Notes; meanings, categories, themes
<p>What do you feel from your experience of working with the community forensic team, having sent in referrals etc., what do you feel are the benefits of having the forensic team in the Health and Social Care Trust?</p> <p>F: Well I suppose from our perspective, it's good that there is a through care system for people, and it works both ways for people coming into the prison system and then obviously going out. And it's the links and the identifying the set people within the team that have come into the prison and it's just tying up and keeping the circle of care from community to prison and back out again.</p> <p>F: There's a clear pathway in and out of prison.</p> <p>M: It's a joined up approach I think between all the services and whatever, that takes everyone in, your PSMA, your prison service, your forensic teams, your general psychiatry, it just joins everyone up together and keeps them all in the link.</p>	<p><i>Pathway- joined up governance.</i></p> <p><i>Collaboration in practice critical! (theme)</i></p>

<p>Any other benefits aside from obviously that kind of joined up approach that you're talking about and the pathway?</p> <p>M: Well the teams are, they're an essential part of the thing to identify risks in the community.... identify risks and triggers, and then do something before anything comes to a head with their one-to-one knowledge of the client.</p> <p>F: And my client group to manage successfully incoming people...</p> <p>M: I think also the public, it's a good thing that there is a dedicated forensic team there that are watching the people....forensics are dedicated to looking after them, to try to ensure there's no recurring practice whatever.</p> <p>F: So it enhances public safety and I guess the public feel safer as well that they know that there's a service out there that's managing these key individuals within the community. And from the individuals' perspective, individuals do better if they're in their own home environment and so it's good for them in terms of their own life, and that's a big part obviously of preventing the re offence hopefully.</p> <p>F....forensic team is a valuable resource for information, for advice</p> <p>M....the forensic team, it's a sort of a two way link here</p> <p>F... its support for us because we meet quite a lot of people who we know need or have been as you say with forensic teams and they may not be a current client but maybe even a bit of knowledge and a bit of advice about what to do with people who have previously been clients.</p> <p>M.... we work with offenders primarily with the Probation. So the input of forensic services is actually new to me.</p> <p>We work with individuals classified as having severe and enduring mental illness and also pose significant risk to others... overall benefits?</p>	<p><i>Risk Management key point (Theme?)</i></p> <p><i>Public safety</i></p> <p><i>Reoffending – treatment responsivity important (Theme)</i></p> <p><i>Living environment plays a role in minimizing reoffending</i></p> <p><i>Collaboration advantage</i></p> <p><i>Working together, sharing info. – Effective collaboration critical!! (theme)</i></p> <p><i>Good to have a fresh view</i></p>
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<p>F: The only other thing is I think that when you [unclear] some of the referrals that are being sent into [unclear] straight to the forensic team to be triaged is good.</p> <p>Is good.</p> <p>F: It's got to be a good thing, because we had a couple of people that.[unclear] we couldn't get linked into services</p> <p>So knowing where the referrals go ...</p> <p>[Talking together]</p> <p>F..... Who sees this person, is it forensic, is it not, does it go to primary or secondary, and I can't answer them things.</p> <p>So at least you know it's going there ...</p> <p>M: ...Forensics if they keep in contact with people who don't turn up for their sessions because maybe ring alarm bells to all the agencies involved, find out where they are, so it's again protecting ...</p> <p>How important do you think the environment, the manner and the setting is for a person receiving forensic mental health service?</p> <p>F.....I think the more people in community who could be managed safely obviously for themselves and for society the better</p> <p>M: It depends again too on as you say the client, everyone's different no matter where you see them, where it's safe to see them or whatever the case might be.</p> <p>F: And I think from a healthcare perspective too, you know, you've come to see me, you're seeing me in a very clinical environment too, whereas I go into your home, it's not just you I see, I see how you're coping in that, and maybe have a chance to speak to your husband, your carer, whatever, you see a bigger picture. But it doesn't always work for the individual to be managed at home.</p> <p>Group work, like offending behaviour programmes versus one-to-one work....what works better?</p> <p>F: Well again it's a very individual thing</p>	<p><i>Referrals process – Ok</i></p> <p><i>Helps avoid people falling through the net!</i></p> <p><i>Risk management – public protection</i></p> <p><i>Community rather than institution</i></p> <p><i>Safety first!</i></p> <p><i>Clear perspective-home is best – whole picture presented</i></p> <p><i>Living environment an issue for treatment??? (theme)...Follow up in next studies</i></p> <p><i>Need for 'best fit' treatment interventions (theme)</i></p>
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<p>M: It's a personality, ...some people would benefit from one-to-one, some would benefit from groups and feedback say from groups</p> <p>F: Some people would destroy a group for other people.</p> <p>M: It's just sort of assessed and planned for what's best for everybody....some people are disruptive in groups, and some people take over groups ...</p> <p>Whatever you feel that that individual will respond to.</p> <p>M: I know, you know, people, schedule one sex offenders that have been on a community assessment with a treatment programme.....come back to the A (name) with quite emotional issues.....because of the nature of the group work....</p> <p>It's not just about the group work but it's about maybe the after, after that as well.</p> <p>F: I also know there's a sort of risk factor as well. I mean obviously we do quite a lot with sex offenders as well. In a group setting, they would feel that there are occasions when some of those people would abuse that, and they even learn from them, the other folk.</p> <p>M: They feed off each other.</p> <p>F: Obviously that needs to be very closely assessed as to whether that's the best.</p> <p>The next question is what do you think of higher risk offenders....have been assessed as more at risk of offending, of needing more intensive treatment</p> <p>F... I think it's all proportional to need and risk level.</p> <p>M....These come down to risk assessments....have to be focused and they have to be thorough, but there's no point. At the minute the way I see things going because of all the cuts... they want all the service but don't want to pay for the resources to staff them properly....how do you protect your staff, how do you protect the public if there's nothing there?</p>	<p><i>Special groups require special arrangements</i></p> <p><i>Risk management issues in group treatments- need for good assessments!!!</i></p> <p><i>Risk management Assessments</i></p> <p><i>Treatment proportional to risk</i></p> <p><i>Cuts – resources inadequate (governance issue? – Theme) Cuts - Risk impacts. (Explore?)</i></p>
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<p>So if you had the resources then, what do you think it should involve? If you have one of those high risk people?</p> <p>M: The new criminal justice orders makes things simpler, with people being released under licences, and it's easier now to have people recalled.</p> <p>F... [Talking together] there's not the volume of Probation staff to actually police the whole thing properly.</p> <p>M: You take...prison service, someone comes through the hospital....it's like someone doing a driving test...they take driving lessons to pass the test, not to be the driver. They're assessed on what they do in hospital not what they're doing outside....</p> <p>F: A lot of its funding basically.</p> <p>Personal wellbeing and how they feel about themselves.</p> <p>M: But then you have to be realistic, why did the person get themselves there in the first place, and why are these restrictions put there?</p> <p>F: I think it's all right having restrictions in, but is it enough just to put an order with restrictions knowing that, is restrictions the right way to go? You know, should we be looking at well what else could we do instead of saying you must not go to somewhere that sells alcohol.</p> <p>F: And I suppose there are resource issues there as well, because we probably would most prefer this personal goal to or whatever, for example some sort of treatment programme...</p> <p>M.... if there is a risk to, if that person was going to stay somewhere and there's a risk to the family, then I would make a decision whether to accept that person or not. And then I would put on extra conditions.</p> <p>Do you feel it's important to target both social, physical and mental health problems as well as the offending problems</p>	<p><i>New laws help</i></p> <p><i>Resources!!</i></p> <p><i>Issue of next step?</i></p> <p><i>Restrictions for public safety</i></p> <p><i>Treatment for public safety (theme interventions; responsivity)</i></p> <p><i>Conditions re living environment. e.g. hostel</i></p>
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<p>F....the peoplethe way that we manage it, we try to look at all those elements, and there's a risk assessment tool that we've been trained in that would certainly look at all those things...doesn't sit in isolation from the others; someone's emotional wellbeing can impact on their offending behaviour and likewise alcohol abuse or whatever.</p> <p>M: Well you have to look at ...offenders, why do you have them, because they were caught, they didn't give themselves up....they're not there off their own volition in the first instance....you know, and they're quite happy to continue in the behaviour they're in when they got caught.</p> <p>F: I have to disagree with that, I really do. Because the person I was talking about with the alcohol, this is a man who is bipolar, who stopped taking his medication.</p> <p>F....there is a core group of people who are genuinely very unwell, who disengage for whatever reason, it should be a relationship breakdown or whatever, and they come into prison, and I think that's a sad statement for us too.</p> <p>There needs to be close working with other teams and agencies. So do you feel that there is enough of that happening or not?</p> <p>F: From our perspective, yes I would say yes, and it's getting better by the day.</p> <p>F: And I agree with that I mean a number of years ago we wouldn't have had the opportunity to have someone like yourself come to meetings that we have, and it's very, it's totally invaluable.</p> <p>F.....You know, we know most of the keyworkers and stuff, so at least you know the people you're talking to, and they know us.</p> <p>What do you think are the most important things a forensic service could be doing to ensure long lasting change with the mentally disorder offender?</p>	<p><i>Wellbeing important - holistic approach</i></p> <p><i>Managing by control perspective</i></p> <p><i>Different treatment perspective</i> <i>responsivity</i></p> <p><i>(Theme)</i></p> <p><i>Prevention and treatment issues</i></p> <p><i>Team working – collaboration essential (theme)</i></p>
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<p>F: Because I think if you look at England, and even look at the South, they have supported accommodation for their mental disorder offenders.</p> <p>F...you take them from, like even the prison like structure... then they go out into the community, and if they're lucky they get into a hostel, if they're lucky they have a family to support them. If they're really lucky they go to somewhere of their own or they're on the street.</p> <p>M: Even the release type scheme if there's structured step down, there's proper professionals that help, lead them through it and move them on from there.</p> <p>F....a lot of these guys...not the nicest people in society, you know, so nobody really wants them when it comes to accommodation. So any excuse and they're out. So you need somewhere that has a very high tolerance level of not antisocial behaviour but of deviant type behaviour.</p> <p>Is there any other points you'd like to raise, anything maybe that you were hoping to say that I haven't asked you today?</p> <p>M: Well I think it's very important that forensics get together with somebody and they look at a very, at a step down process and well structured, well run, well managed.</p>	<p><i>Supported accommodation</i></p> <p><i>Living environment Choices???</i></p> <p><i>Step Down (Living environment theme)</i></p> <p><i>Step Down (Living environment theme)</i></p>
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Professional (Forensic Psychiatrists) Focus Group Transcript

Several areas from the extracts were removed and words (names) deleted to protect anonymity

<p>Transcript: sifting, highlighting, - key words and phrases, etc.</p>	<p>Notes; meanings, categories, themes</p>
<p>What do you feel are the benefits of having the forensic team in the Trust?</p> <p>M: It's a specialised risk assessment</p>	<p><i>Risk management (theme) - complex cases!!!</i></p>

<p>M.....to facilitate complex cases coming through, certainly through the front door ...service of complex cases, whether it's risk, history of offending behaviour and reoffending, so complex risk assessments in these cases.</p> <p>M: It's access.....the additional community mental health team.</p> <p>M: Whether that be for guidance and direction, or whether it would be for assistance or key working or whatever.</p> <p>It's not just about the risk assessments, maybe advice and consultation as well.</p> <p>M. more collaborative working, because there's a level of expertise within the forensic service that you wouldn't have within the more traditional community mental health team M. the treatment component; if it's okay and successful it's the actual interventions that a lot of the patients do find helpful providing them with an opportunity just to be a bit more reflective and looking at how they got to where they got and learn from that..... Another strength I think is the fact that there's a recognition within the forensic team in terms of resources, it's time, you know, and that's the critical thing. Being able to do the more comprehensive risk assessments, and specialised risk, it takes time, but it's being able to have that, being able to do that. Whereas I think in general a lot of psychiatry it's constant firefighting You don't have that luxury to sit back and, you know, as much as you'd like to be able to.</p> <p>M: So to be able to sort of say right for this period of time, we're going to get this extra wee bit of input and get this other information altogether, a good risk formulation put together, and then a bit of direction in terms of responding. Sometimes co-working and I think that's important, and then other times it's being able to feed into working with the community team or the, at the inpatient level in terms of the risk management plan. Against that there's, I suppose the difference is [unclear] in forensic services</p>	<p><i>Teams –access critical!!</i></p> <p><i>Key worker role-define?</i></p> <p><i>Collaboration (theme)</i></p> <p><i>Treatment interventions are v. important</i></p> <p><i>Resources and time pressures – governance issue?</i></p> <p><i>Making the best use of resources</i></p> <p><i>Teams/Groups</i></p> <p><i>Co working- good!! (Collaboration and support theme?)</i></p> <p><i>Team recognition!</i></p>
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<p>pre-community forensic team where we would have asked for ad hoc forensic assessments, and the difficulty again was there's was an awful lot of recommendations that weren't resourced, we hadn't, we couldn't put into place. So I think the advantage of the current system is people are making recommendations of things that they know can be resourced.</p> <p>Followed through on.</p> <p>M.....I think prior to this service, sometimes you felt a forensic opinion was addedbut also almost exposing us to identifying all that need and potentially being criticised for not being able to address the issues that were raised</p> <p>Treatment being delivered in the community, treatment being delivered in a group format rather than individual format, just wondering how important you think that is.</p> <p>M...group work would have been seen very positive... and in a lot of cases more positive than on the one-to-one work....one-to-one work done in collaboration with the likes of community mental health teams</p> <p>M....keyworkers from the team have been out, individuals in the family have been sort of saying I haven't seen anybody from forensic, and vice versa</p> <p>M.... clients that have been involved can see it from a very positive point of view.</p> <p>M: The setting of it, whether it's coming to the hospital setting or is going out to the community, a setting like that, don't seem to have significance one way or other.</p> <p>M: And, you know, it's accessible (local setting) for them because they're living in this locality...</p> <p>When we asked the question to service users themselves what they like, they said that they liked a combination of different things. That they liked the group work and they liked the one to one work as well. They also said that, some of them said that they liked</p>	<p><i>Targets - Benefits are realistic Treatment and responsivity (theme?)</i></p> <p><i>Better risk management resulting from team being put in place</i></p> <p><i>Groups seen as positive; one to one has its place as well – Best Fit!!!</i></p> <p><i>Collaboration again mentioned (Theme)</i></p> <p><i>Role of key worker-family support!</i></p> <p><i>User view good</i></p> <p><i>Treatment setting not significant</i></p> <p><i>Local setting is best – accessibility a factor</i></p> <p><i>Service user views from previous focus group- Feedback to Forensic Psychiatrists- to gauge reaction!!</i></p>
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<p>forensic practitioners going out to their homes to see them as well as coming in here, because they felt that whenever they come in to wherever that they were masking how they really were, and they liked being seen at home because it demonstrated the real them, who they really were.</p> <p>M: Well I think from the point of view of best practice it's a combination I suppose because it's important to see what's going on in the home. I think that idea of masking is very valid, particularly if there's other issues, whether there's maybe child care issues or adult issues or whatever that we're supposed to be looking after the family as a unit, the impact...</p> <p>Do you feel that we should focus more on the higher risk offenders or not so?</p> <p>F: If they're at risk of, high risk. (yes)</p> <p>M: Maybe with a group of high risk of reoffending offences, than a normal population with drunk and disorderly behaviours and sort of minor violence, theft and criminal damage and that type. But the more so (very criminal serious) offences...the patients come down from (external secure unit)... I think that's the interface that hasn't quite tied up as yet</p> <p>M: I think, well they're obviously still a void in terms of community based forensic services</p> <p>Yeah, they're going from one (place), there's no step time.</p> <p>M: And that's part of the issue where sometimes patients are coming from an edge facility.</p> <p>M but that's even a problem within general services; there's no step down, that's been done away with. It comes from the acute unit to the big wide world, there's no sort of step down</p> <p>M. We're sort of slipping back to what was, used to be high secure [Carstairs?], and low secure the X so patients who are well, engaged in rehab, suddenly go back into an acute</p>	<p><i>Concurrence</i></p> <p><i>Family involvement and support (theme)</i></p> <p><i>Stigma / fear</i></p> <p><i>High risk priority</i></p> <p><i>Interface – collaboration issue?</i></p> <p><i>Stigma!</i></p> <p><i>Step down – from secure unit to where???</i></p> <p><i>Becoming a major issue!!!! Impact on treatment regimes, families...</i></p> <p><i>Sums up problem!</i></p> <p><i>Need for major review – step down again and again an issue – take into account in treatment themes, etc.</i></p>
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<p>setting, and then what tends to happen is that if somebody's been stepped down, they often step down onto the admission ward....which is far from ideal, and getting them engaged because there isn't as much resource as inpatients in terms of the forensic.</p> <p>So there is a gap for those higher risk... So what do we do in those cases then?</p> <p>M: Well at the minute there's a lot of making do.</p> <p>M: Unless we go back to the sort of holistic ...yes there's psychological dimensions are important, but they're only important if somebody's stable enough So the inpatient environment or those that are stable at home families or good supported families, but it's the group in between that you could try and engage them...</p> <p>M: And then the physical treatments...the treatment's as much about somebody getting them up in the morning, pointing them in the right direction during the day, ensuring that they're fed, looking after them</p> <p>That's exactly what the service users were saying to us. One guy was saying, you know, for me it's about getting out and actually making human contact with people, and meeting people...self-esteem....</p> <p>M: And I think (that – the patient wellbeing) is the main driver...</p> <p>M.... From the professional perspective we would say yes risk management is an integral part of the overall package, but it's not the be all and end all.</p> <p>M....I suppose in terms of the co-working, sometimes there is a bit of a concern that community teams aren't resourced and able to provide that services component... you're carrying a caseload of 60 or so people, you're not going to be able to do (all)..</p> <p>M... there's something to the whole systems approach</p> <p>Sometimes in the past it's been, you know, we deal with the forensic bits and then other people deal with</p>	<p><i>Holistic approach works</i></p> <p><i>Family support again!</i></p> <p><i>Doing the basics is important in Treatments to get good responsivity</i></p> <p><i>Psychological wellbeing (Theme)</i></p> <p><i>What works- More than risk management (theme)</i></p> <p><i>Co working - Collaboration (Theme)</i> <i>Resource issue (Governance)</i></p>
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<p>maybe the mental health and social side and their physical problems, but it's about the holistic.</p> <p>M: It's all about co-working.</p> <p>How important do you think it is that treatment is delivered in a way that patients understand, i.e. responsive to the learning style and ability?</p> <p>M....on the whole generally positive.</p> <p>M....fortunate enough to work on teams where there has been a number of people maybe psychosocial change specific who have a greater in-depth knowledge of medication management issues....would there be a bit of potential for the likes of forensic services to utilise those agencies to come in and be part of a group?</p> <p>M....there's other people who would have expertise in other areas that's not being tapped into.</p> <p>M....this holistic approach, I think we have to follow right through the whole way.</p> <p>M....the groups are good and basically from that perspective, it's the patients who won't engage in the group and they won't engage in the individual work. You get it at the risk assessment point, when the practice nurse comes back saying this person's really made it clear they don't want to engage....Instead of sort of looking at it from the other perspective and saying well the fact we've identified he's going to be difficult to engage, actually makes it more of a challenge....our risk management planning.</p> <p>M... bit defensive in saying well we say we'll offer something and they don't engage, it's going to create a problem for us</p> <p>M... it's more than just how you motivate, it's how you motivate a group....</p> <p>M...It's how you have to engage with them to get them to get doing the work</p> <p>M.... eventually got him to address some of his addiction problems, some of the compliance problems, but we</p>	<p><i>Good feedback</i></p> <p><i>Working with others; cross cutting issues – learning shared (Collaboration theme)</i></p> <p><i>Holistic – Good Lives!!</i></p> <p><i>How we provide treatment Engagement issue</i></p> <p><i>Holistic wellbeing</i></p> <p><i>Treatment interventions – responsivity (theme)</i></p> <p><i>Motivation and engagement linked</i></p> <p><i>Change – penny drops!!!</i></p>
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<p>haven't got him to the point where the penny's really dropped. And that's the change, that's the behavioural change that's going to take that long time, and that's where, none of the community facilities are going to touch him.</p> <p>M....motivation is such a key factor...trying to get them to chip away and chip away and chip away</p> <p>Community forensic mental health team - close working with other teams and agencies?</p> <p>M. Yes</p> <p>M: There's good communication as far as risk assessments</p> <p>M...in England, forensic services has always been a completely separate service and entry into it's impossible for the clients, exit out of it was impossible...Here NI there's as much integration as possible. Busy, I think that's the difficulty, like at the minute there seems to be an awful lot of referrals... then alongside that you have the criminal justice system as well so I'm sure the prisons are sort of creating a lot of work for you as well...., I actually think that the face-to-face (helps understand)</p> <p>It's interesting that you've picked up on that, sometimes it's the face-to-face communication as well as maybe the big sophisticated report. The next one; well-resourced and skilled staff, we could always do with more resources...in terms of the skills that you have experienced, do you feel that people are skilled up?</p> <p>M....there's such different styles within the team... sometimes there's very different approaches; it isn't always uniform. You know, you couldn't say one's better than any other... because it evolved the way it evolved.</p> <p>M: But that's the same as every team. You know, teams are constantly changing with people coming and going. In terms of knowledge base and everything else, there's no issues at all, the staff are good.</p>	<p><i>No overnight solution for some – perseverance required-</i></p> <p><i>Good Professional characteristics (theme)</i></p> <p><i>Communication-governance</i></p> <p><i>Integration – explore</i></p> <p><i>One to one and face to face – same as family and patients</i></p> <p><i>Good Professional characteristics (theme)</i></p> <p><i>Team approach – staff assets</i></p>
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<p>In terms of accessibility then, and easy to refer into, are we easy to get hold of?</p> <p>M: I think that's a big strength here....</p> <p>M.. the comprehensive risk assessment could well (improve)</p> <p>Good reports, risk assessments clear and understandable?</p> <p>M: Yeah.</p> <p>Contributed to mental health education?</p> <p>M...induction programme...the medical students now have the opportunity as well.</p> <p>M.. we do a child protection... we do our own sort of case presentations and wee of education on there</p> <p>What do you think the key things are that we should improve on as a service?</p> <p>M...those clients that are proving difficult to engage... any untested models elsewhere</p> <p>M....support programme care....</p> <p>M... psychological therapy and then try and move them away from that other service</p> <p>M... no resource for this (action) but it prevent some of them progressing into that severe state [unclear].... progress into the sort of recovery and support a programme of care...</p> <p>If there was absolutely no restrictions on funding, resources, services etc., what would the service look like</p> <p>M: I think the big one isyou need the step down.</p> <p>M... keep it focused on the bit that you have...for the period of time that they need that input, and then a small group that needs to have longer input and able to do that.</p> <p>M: Information, psychological work done, it's like the process of being on a group and that social interaction with other people</p> <p>M...what do we do now....and they (patients/group) come up with some ideas themselves</p>	<p><i>Access is good – Treatment interventions</i></p> <p><i>Admin /policy issue? – governance</i></p> <p><i>Training</i></p> <p><i>Sharing knowledge (Collaboration and support theme)</i></p> <p><i>Undertake research of best practice elsewhere</i></p> <p><i>Family support</i></p> <p><i>Resources Governance (theme)</i></p> <p><i>Step down requirements crucial</i></p> <p><i>Social – Wellbeing</i></p> <p><i>Users have a role.</i></p>
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Phase Four: Development of Themes

The table below encapsulates and illustrates the frequency of key expressions and inferences, which were extracted from the researcher comments and observations set out in the extracted transcripts of the focus groups. These reflected the preliminary list of ideas in phase two: coding, and evolving process of theme development in phase three: interpretation. Both implicit and explicit considerations were applied. The data is presented in descriptive categories and patterns of association which point to the emergence of significant themes. Appendices 8.9 and 10 summarise the main messages and reinforce the development of the themes.

Major related Inferences	Patient	Families	Professional	Total
Risk / Risk management assessment	6	5	9	20
Key worker -support	5	4	2	11
Treatment- plans-access	18	3	3	24
Treatment (interventions) Groups, Consultant	4	7	6	17
Therapeutic alliance re treatment	2	1	1	4
Patient response to Treatments (responsivity)	10	2	5	17
Teams – Collaboration Co working	4	2	16	22
Living – step down	4	1	11	16

Home, Hospital	8	8	5	21
Locality, places	2	2	3	7
Family role	4	10	5	19
Support for families	2	5	5	12
Wellbeing, Anxious, Fear	4	3	3	10
Social	10	5		15
Holistic	3		5	8
Public perceptions, Stigma, Education, Awareness	3	5	5	13
Professional – traits. Characteristics- Therapeutic alliance	6	4	3	13
Time, Money - Resources	6	2	6	14
Management issues - Governance	6	3	1	10

At this stage, the final analysis included a further consideration of the data in phases two and three in terms of extensiveness, specificity, and intensity of expressions and observations, and also ideas thought worthy of exploration in studies two and three. As a result, more definitive themes were emerging, and following a refinement of the linkages between the textual extracts, the observations and comments, and the inferences, a strong list of ten themes resulted. In order to apply rigour to this stage of the research, the process and key data were reviewed independently. The rehabilitative models, aims, and objectives of the research were referred to as part of the process.

At the end of this phase (four) ten relevant themes were produced:

1. Risk Management

(Risk / Risk management; assessment; key worker (31);

2. Treatment Interventions

(Treatment – plans – access; Treatment (interventions); Groups;
Consultant (41);

3. Treatment and Responsivity

(Patient response treatment (responsivity); Therapeutic alliance (21);

4. Collaboration and Support

(Teams, collaboration, co-working (22);

5. Living Environment

(Living – step down; Home – hospital; Locality, places (44);

6. Family Involvement and support

(Family role; Support for families. (31);

7. Psychological Wellbeing

(Wellbeing, anxious, fear, social; holistic (33);

8. Public Perceptions and Awareness

(Public perceptions, stigma, education, awareness (13);

9. Professional Characteristics

(Professional – traits. Characteristics (13);

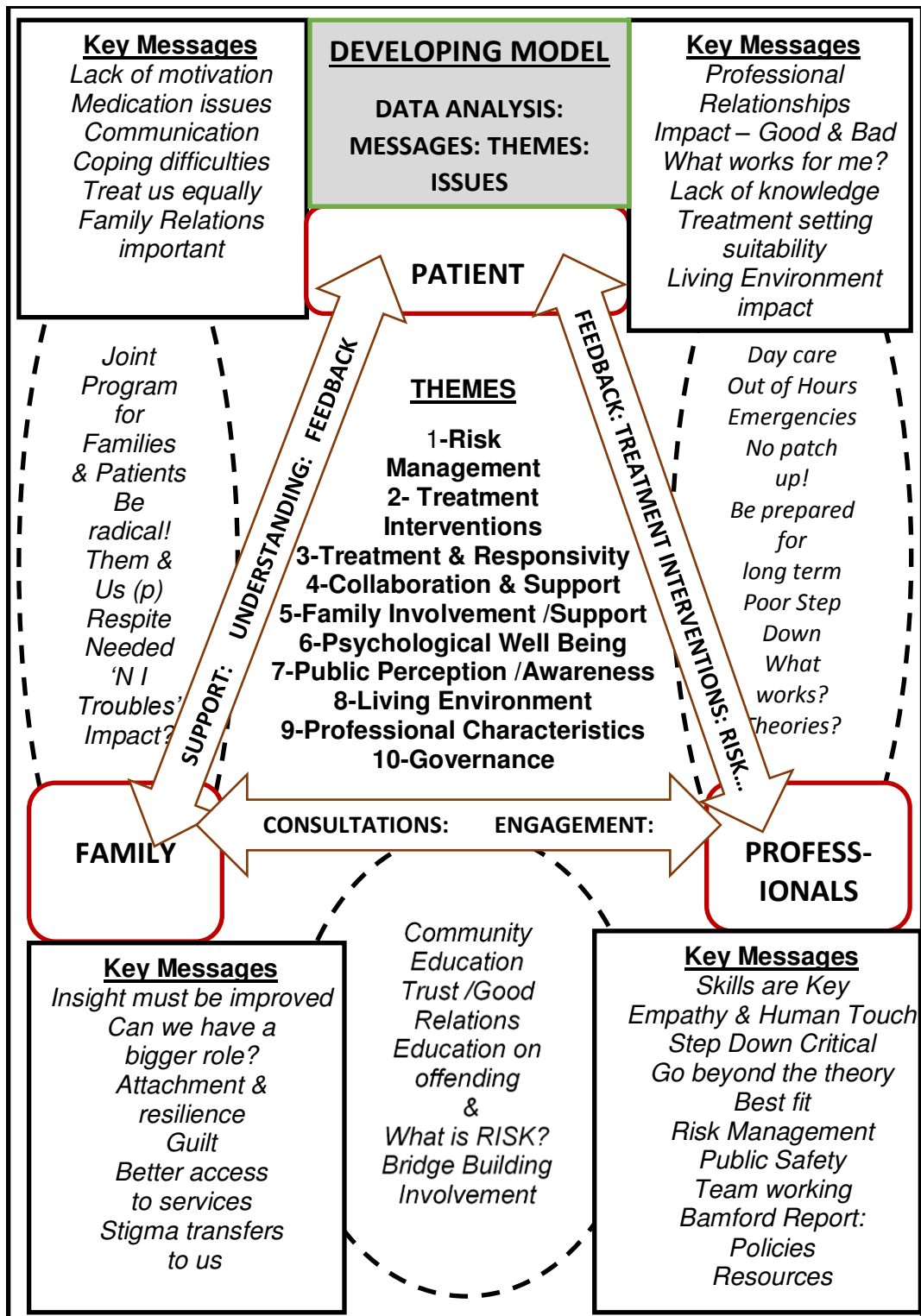
10. Governance

(Time, money – resources; Management issues – Governance (24).

Summary and Evolving Model

The methodology of the chosen thematic analysis approach, as set out in the phases above, was successfully delivered and produced the ten major themes, which form the spine of the further studies reported in this thesis. The ten major themes were found to be consistent across the three focus groups of patient, family and professional. Within the ten themes, key messages for the three groups were identified. The analysis revealed similarities and differences in these messages across the three groups, which are outlined in the results section.

From thematic analysis of the focus groups an evolving model was developed to capture in diagrammatic form the key findings which were used to inform the subsequent studies. It is set out below.



4.4 Results of Focus Groups

The following results are a summary of the themes and the associated key messages that emerged from the focus groups under each theme. Appendix 11 shows in tabular form the detail of these messages from the three groups, thus enabling a comparative assessment under each theme. It should be noted that in the Appendix the professional group is separated into two sub-categories, Mental Health Professionals and Criminal Justice Professionals / Accommodation Managers, to facilitate the completion of a more detailed analysis.

Overall, the ten themes are largely reflective of the three main offender rehabilitation models: 'What Works', 'Risk, Need Responsivity', and 'Good Lives' models.

Theme 1: Risk Management

This is defined as the management of the offender/patient's risk and includes both risk of offending and mental health deterioration;

Patient Perspective: The key messages of offenders from the patient perspective with regard to risk management include:

- *'The importance of professionals in a patient's risk management. In particular, the role of the key worker and their ability to identify warning signs of risk of offending or mental instability';*
- *'Everyone should get the same standard of care regardless of risk';*

Family Perspective: The key messages from the family perspective with regard to risk management include:

- *‘A balance between security and recovery is needed’;*
- *‘Communication regarding a person’s risk level needs to be clearer’;*
- *‘Securing the ‘best match’ between a person’s risk assessment and treatment plan’;*
- *‘The importance of the role of the key worker in managing risk and mental health’.*

Professional Perspective: The key messages from the professional perspective with regard to risk management include:

- *‘Too much emphasis on risk management which can create a ‘risk adverse’ culture, negativity and defensive practice’;*
- *‘Concerns about how risk assessments are being undertaken. Preventative risk management is important’;*
- *‘Small caseload aids better risk management and identification of warning signs’;*
- *‘Public need educated on risk’;*
- *‘CFMHTs have an important role in risk management’.*

Comparative Summary

All three groups agree on the importance of the key worker in managing risk and mental health. The professional group place more emphasis on the need for good risk-management arrangements; however, they also raise some concerns about placing too much emphasis on risk management, which they

feel can potentially lead to a 'risk averse' culture. To some extent the family agree with this opinion, believing there should be a balance between 'security' and risk management, and recovery of the individual. The patient and family group agree that risk management arrangements should be responsive to a person's individual needs, which is reflective of the 'Risk, Need Responsivity' model (Andrews and Bonta, 1995).

Theme 2: Treatment Interventions

This is treatment interventions for offenders/patients. What is seen as important from the perspective of the three groups?

Patient Perspective: The key messages for offenders from the patient perspective with regard to treatment interventions include:

- *'Treatment should not just look at forensic needs but also general wellbeing';*
- *'Help for mental health is important';*
- *'Sometimes people offend because of poor mental health';*
- *'Would benefit from 'one to one' work outside of therapy groups and follow up work after group therapy';*
- *'Group therapy provides a social outlet for meeting people';*
- *'Groups are good at addressing general life problems as well as offending issues'.*

Family Perspective: The key messages from the family perspective with regard to treatment interventions include:

- *'Forensic cognitive groups are a positive treatment intervention';*

- *'A group to help families understand why their family members have offended would be a source of support for each other';*

Professional Perspective: The key messages from the professional perspective with regard to treatment interventions include:

- *'Groups provide patients with an opportunity to be reflective and learn from past behaviour. They also offer a form of social interaction. They are specialised (and benefit from that) and demonstrate/ manifest the expertise of the CFT';*
- *'Group work would benefit from individual follow up work. There is a sense of loss for patients when the group finishes';*
- *'There needs to be more mapping and step down approach from secure hospital and hospital generally to the community. Structured step down that is professionally managed is an essential requirement';*
- *'People are assessed on what they do in hospital - but is it appropriate for this assessment to be transferred into the community? Otherwise there is a good risk of failing';*
- *'Treatment depends on the individual and should be responsive to their needs. Group dynamics is important in managing difficult personalities'.*

Comparative Summary

All three groups agree on the importance of cognitive-based groups for forensic patients as a positive treatment intervention. This is identified as important in academic research (McGuire, 2000); (The Sainsbury Centre,

2000). Families advocate for a separate educative, supportive group to help them understand why people offend and also the link between mental illness and offending behaviour. Professionals emphasise the importance of a 'step-down approach' when patients' are moving from security to more independent living. Patients would like treatment interventions to be more holistic, not just about offending needs, but also about social care support and general wellbeing, which is reflective of the 'Good Lives' model .

Theme 3: Treatment and Responsivity

This explores what works best for offenders/patients; what treatment is most responsive to a person's needs?

Patient Perspective: The key messages for offenders from the patient perspective with regard to treatment and responsivity include:

- *'Treatment should always be responsive to an individual's specific needs';*
- *'Everyone should be given same standard of help regardless of risk level'.*

Family Perspective: The key messages with regard to treatment and responsivity for offenders from the family perspective include:

- *'Interventions need to be responsive to a person's needs';*
- *'Acknowledgement that people with mental health problems can be hard to motivate or engage in treatment – family feel pressure to do this'.*

Professional Perspective: The key messages for forensic patients from the professional perspective with regard to treatment and responsivity include:

- *‘Patients who are difficult should not be avoided or given up on, but rather worked with until ‘the penny drops’;*
- *‘Treatment should be proportional to risk and need level’.*

Comparative Summary

All three groups agree that treatment should be responsive to an individual’s specific needs, which is reflective of the ‘Risk-Need-Responsivity’ model. Both the family and patient group agree that forensic patients can be difficult to motivate and engage in treatment at times. Professionals believe that this group should not be ‘avoided or given up on’ because they are more difficult to treat. Patients believe that everyone should be given the same standard of care and help regardless of risk level. This is also reflective of the literature on the ‘Good Lives’ model (Ward, 2002), which suggests that the wellbeing of individuals should be the primary aim in rehabilitation.

Theme 4: Collaboration and Support

This explores support and collaboration in the working relationships between different professionals and how this impacts on treatment and rehabilitation.

Patient Perspective: The key messages with regard to collaboration and support include:

- *‘Patients’ perceive working relationships between professionals as positive’;*

Family Perspective: The key messages with regard to collaboration and support include:

- *‘Team working amongst professionals in the Trust could be better’;*
- *‘The interface and communication between hospital and the community services could be improved, i.e. when someone is being discharged from hospital’.*

Professional Perspective: The key messages with regard to collaboration and support include:

- *‘There needs to be better co-working between teams’;*
- *‘More education required for teams on forensic services and working with forensic patients’;*
- *‘The links between the police, probation, and health service are positive’;*
- *‘More face-to-face communication required between forensic services and other teams re: forensic patients’.*

Comparative Summary

Both the family and professional group agree that collaboration and support between teams could be better. The patient group perceive working relationships between teams as positive. The professional group advocate the need for increased education about what forensic services do, and how to work best with a forensic patient. In this theme the family and patient group are more similar in their views.

Theme 5: Family Involvement and Support

This focuses on the role of the family in the risk management and rehabilitation of the forensic patient.

Patient Perspective: The key messages with regard to family involvement and support include:

- *‘Patients feel their family have confidence in the treatment provided by CFT for them’;*

Family Perspective: The key messages with regard to family involvement and support include:

- *‘Family advocacy role needs to be enhanced and structurally recognised’;*
- *‘Peer advocacy to influence choice is required’;*
- *‘Courses and training by Community Forensic Team for families would be helpful’;*
- *‘A Forensic support group is required for families’;*
- *‘Respecting patients’ rights but also family rights’;*
- *‘Balancing security with recovery’.*

Professional Perspective: The key messages with regard to family involvement and support include:

- *‘Believe it is important to work with the family and understand the family dynamics and set up’.*

Comparative Summary

All three groups agree that the family have an important role to play in supporting a forensic patient through treatment and assisting in their risk management. The family emphasise the need for a group tailored specifically for their needs, which would provide support and education. The professional group see working with families as vitally important. The importance of a positive family relationship is suggested in the 'Good Lives' model.

Theme 6: Psychological Wellbeing

This relates to the impact of forensic mental health on patients and their families.

Patient Perspective: The key messages with regard to psychological wellbeing include:

- *'The groups (treatment programmes) provide an important social outlet; this is an opportunity to make friends';*
- *'Community Forensic Team increases your motivation generally, especially in relation to addressing mental health and offending behaviour';*

Family Perspective: The key messages with regard to psychological wellbeing include:

- *'Family members feel that the patient (family member) often has a fear regarding their own mental illness and hides symptoms from professionals';*

- *'There needs to be more of a shared understanding between patient, family, and professional of difficulties and problems and what constitutes 'health and wellbeing';*
- *'Differences between family and professional as to what is reality and perception regarding mental health'.*

Professional Perspective: The key messages with regard to psychological wellbeing include:

- *'Groups are a positive intervention and useful for managing 'difficult personalities';*
- *'Patients would benefit from targeted follow-up interventions to assist in managing difficult emotions that may arise as result of group work'.*

Comparative Summary

Both patients and professionals agree about the importance of groups in managing psychological wellbeing. This is reflective of research, where it is stated that those offenders with mental health problems who undertake groups do better compared to individuals who do not (Wilson, 2007). The professional group emphasise their usefulness in managing 'difficult personalities', whereas the patients view groups as an important social outlet and an opportunity to 'make friends'. Families feel that there should be better communication and more of a 'shared understanding' between patient, family, and professionals with regard to what constitutes a problem and mental wellbeing. Families feel that patients often hide their mental illness from professionals.

Theme 7: Public perception and Awareness

This is about the perception the public has regarding forensic mental health and rehabilitation and recovery

Patient Perspective: The key messages with regard to public perception and awareness include:

- *‘The PSNI (police) need to be aware of the impact of mental illness on offending – so they ‘know you are not wild like’;*

Family Perspective: The key messages with regard to public perception and awareness include:

- *‘Community stigma towards people with mental health is still present; situation is improving but more needs to be done through public awareness and education’;*
- *Perception that it is easy to ‘spot’ the person with mental health problems. High visibility of their own family member in shopping centres and ability to ‘pick other people out’ who have mental health problems adds to this.*

Professional Perspective: The key messages with regard to public perception and awareness include:

- *‘Public require education and awareness on forensic mental health. Public safety is important’;*
- *Has society failed some people? When a person ends up in prison – what message can society take from this?*

Comparative Summary

All three groups agree that the stigma of having a mental illness and forensic history is still prevalent. Negative outcomes can be a consequence of stigmatisation for people with mental illness and offending behaviour (Link, Streiening, Rahov, Phelan and Nuttbroack, 1997). Professionals and families emphasise the need for increased public education about mental illness and offending behaviour. Patients also agree with this viewpoint, but believe that the police also need to be educated about the links between mental illness and offending behaviour.

Theme 8: Living Environment

This examines the role the environment plays on persons' mental health and forensic presentation.

Patient Perspective: The key messages with regard to living environment include:

- *The patients did not raise this as an issue in the focus groups. However, given the importance placed on this theme by both the family and professional groups the patients' viewpoint on living environment was further explored through the semi-structured interviews in study three.*

Family Perspective: The key messages with regard to living environment include:

- *'The local environment can be protective of people with a mental illness';*

- *'There needs to be local acceptability and respect of who we are and the mental illness we have'.*

Professional Perspective: The key messages with regard to living environment include:

- *'People as far as possible should be facilitated in the community if they can be safely managed';*
- *'Individuals do better if living in their own environment with the right supports. Environment needs to be the 'best fit' for the individual whether the home or hospital. Seeing the person in their own home is positive. Needs to be more 'supported accommodation' for mentally-disordered offenders';*
- *There is a strong perception (mostly public?) that hostels may not be the most appropriate environment for persons with severe and enduring mental illness.*

Comparative Summary

The patient group did not raise this as an issue of importance. However, both the family and professional groups agreed about the importance of an individual's environment to their risk of re-offending and psychological wellbeing. The family group highlighted the need for 'local acceptability' and that if a person is accepted into their environment then this can be a protective factor. The professional group believe that where possible people should be facilitated in the community if they can be safely managed. This idea is also suggested in the 'Good Lives' and 'What Works' models. The Reed Principles

(1992) also state that people should be managed in the community if deemed safe to do so and that this is part of their rehabilitation and recovery.

Theme 9: Professional Characteristics

This is regarding the characteristics of a professional that are considered important when working with forensic patients

Patient Perspective: The key messages with regard to professional characteristics include:

- *‘Having a named key worker is important. Knowing that person is ‘only a phone call away’.*

Family Perspective: The key messages with regard to professional characteristics include:

- *‘Family believe that the ability to exercise the skills of empathy and understanding the specific needs of the patient are important’;*
- *‘Bridge building’ with family members is important’;*
- *‘Creating the right atmosphere to deliver the message of care and ensuring it is accepted’;*
- *‘Family do have a fear of professionals and the power they have’.*

Professional Perspective: The key messages with regard to professional characteristics include:

- *‘An assertive approach should be adopted and ‘face up’ to the challenge of working with difficult patients’;*

- *‘Community Forensic Team practitioners have specialised skills and links with probation, police and prison (criminal justice agencies). This is an added value of the team in addition to easy access to information such as criminal records, etc.’;*
- *‘Community Forensic Team is a targeted specialism that provides advice, guidance and support to agencies. Knowing one another is an important factor to positive working arrangements. Working from a sound evidence base is important’.*

Comparative Summary

The patient group emphasise the importance of having a named key worker. The professional group focus more on the technical skills of forensic practitioners and the links with agencies, such as probation and the police. The families, in comparison, focus more on the softer skills such as empathy, and understanding the needs of the patients. It is interesting to note that families feel there is a divide or ‘bridge’ between themselves and professionals, and a ‘fear’ on part of the families’ that needs to be overcome. Research would suggest that the therapeutic relationship between patient and professional is one of the most important indicators of positive treatment outcome (Marshall et al., 1999).

Theme 10: Governance

This is about governance arrangements within an organisation and the impact they may have on the rehabilitation and recovery of the forensic patient.

Patient Perspective: The key messages with regard to governance include:

- *'Patients aware of cutbacks and reduction in funds. For example, awareness of one less practitioner in the Community Forensic Team and absence of a secretary when phoning into the service'.*

Family Perspective: The key messages with regard to governance include:

- *'Important to ensure that the primary goal is the service users' needs';*
- *'Resources need to be more focussed and a more integrated approach in the Trust area should be adopted';*
- *'Policy should be flexible to meet changing treatment scenes';*
- *'Treatment location needs to be accessible for families';*
- *'Families need to be consulted where changes are being proposed that may impact on them or their family member (patient)'.*

Professional Perspective: The key messages with regard to Governance include:

- *'A 'whole systems approach' needs to be adopted. Approach needs to be 'holistic'. Interface issues between teams need to be addressed as often lack of 'buy in' to Community Forensic Team from community mental health teams and hospital due to lack of knowledge, education and understanding of forensics';*
- *'Holistic approach needs to be adopted by services with regard to treatment, structures, teams, activities patients engage in';*
- *'A big issue exists between the discharges of patients from secure environments to the community. Need for a 'stepped down facility', 'too big a gap to jump', and 'no soft landing';*

- *‘Pressures within Trust (targets) and outside Trust (risk of public enquiries) have adverse impact on service delivery’;*
- *‘There is an impact of pressures on service delivery and quality i.e. trying to meet targets with limited resources’;*
- *‘There is a lack of resources and the case work pressures, gaps in patient monitoring produces increased risk and potential enquiries’.*

Comparative Summary

The patient group had less to say on this subject in comparison to the family and professional group; however, they are aware of financial restraints and the impact of this on service delivery. There were marked differences between the professional and family groups in the governance theme. The professional group were more focussed on resource constraints and target demands, which impact on service delivery. Conversely, the family group emphasised the need for resources to be more person-centred and for consultation to occur if changes were being made to a patient’s care. Professionals also advocated for better team working and that a more ‘holistic’ approach should be adopted by services with regard to treatment, and the structures and activities that patients engage in.

Appendices 8, 9, and 10, set out the emerging messages and themes for patients, family, and professionals.

4.5 Discussion of Study One: Focus Group Findings

The findings are discussed under each of the ten identified themes.

Risk Management

All three groups agree on the importance of risk management in the care and treatment of mentally-disordered offenders. Ensuring that a patient's treatment is tailored to their individual needs was emphasised by all three groups but more particularly the patient and family groups. Focussing on risk and need is reflective of the 'Risk-Need-Responsivity' and 'What Works' models. DeMatteo et al. (2010) state that recent studies demonstrate that adherence to risk/need models does reduce recidivism. They go on to say that adherence to the basic elements of risk and need in assessment is essential, and that risk is an important consideration when working with mentally ill offenders. The findings of the focus groups endorse this view.

In this study the patient group and family group placed more emphasis on a patient's individual needs in risk assessment, in comparison to the professional group who were more focussed on the process of risk management and managing the level of risk being addressed. This is an interesting difference in terms of the perspectives of the three participant groups. Ward et al. (2007) argue that if treatment is to be '*maximally effective*' it should go beyond risk management and reduction, providing offenders with the motivation to engage. In the current study it appears to be the patient group and family group who strongly advocate attention to individual needs. Interestingly, it is the professional who provides the interventions and whom one would expect to have a strong adherence to individual needs; however, in this study they placed more attention on the process of risk management.

The quality of risk assessments and defensive practice when undertaking risk assessments was raised as a concern by the professional group. In the focus groups the family group more particularly reflected an interest in ensuring a balance between risk management and supporting the recovery and rehabilitation of an offender. The latter point would be reflective of the 'Good Lives' and 'What Works' models, where reintegration of offenders into the community is advocated, albeit in a manner that is safe and proportionate to the risk of offending.

The patient and family groups value the role of their key worker in their risk management, and see this as an important support mechanism.

Overall, the findings suggest some core similarities between the three groups with regard to the importance of risk management, but the findings also imply key differences. The patient and family groups focus more on the 'individual', and the professionals are more inclined to concentrate on issues around the process of risk management. Areas requiring further exploration include:

- The role of the key worker: how and why this is important;
- Characteristics and demographics of the key worker that may impact the relationship with the patient/family of the patient. For example, age, gender, religion;
- The core elements of a risk assessment and treatment plan.

Treatment Interventions

All three groups agree on the importance of offending behaviour groups as a treatment intervention for mentally-disordered offenders. Nevertheless, there

are differences in how this intervention is viewed. The view of the patient group is very much reflective of the 'Good Lives' model, where treatment should encompass multiple elements of a person's life rather than focussing purely on the offending behaviour. For example, the development of social skills, relationships, help with accessing appropriate accommodation, and engagement in positive pro-social activities. The family group stated the importance of support mechanisms for families, which appears to be a gap in service delivery. This view would be reflective of the 'What Works' model, where enlisting the family as a support mechanism, where deemed appropriate, can have a positive effect on risk management.

The professional group highlighted the need for a '*stepped down approach*' in treatment when a patient is moving from a secure facility to the community. 'Step down' could be defined as gradual reintegration of a person from a secure environment to a community environment; for example, from security to supported living rather than straight to independent living. This is reflective of the 'Risk-Need-Responsivity' model, where a patient's treatment should be matched to their individual needs.

A secondary benefit identified from treatment groups is the social outlet and interaction that such groups provide. This aspect was also highlighted in the risk management theme and is reflective of the 'Good Lives' model, which suggests that treatment for offenders 'must regard individuals as whole beings in need of focus in many principal areas e.g. family, employment, leisure, community, and personal wellbeing' (Wilson and Yates, 2009 pp157-161). In the current study the patient group saw participating in groups as a community-based activity and something of real value.

Overall, study one reflects the point that all three groups agree on the importance of therapeutic groups for people with forensic mental health needs. The professional group advocated strongly for a '*stepped down*' approach. What this would look like is explored further in study three to be reported below. Families especially want a support mechanism for their needs.

Treatment Responsivity

All three groups agree that treatment for mentally-disordered offenders should be delivered in a way that is most responsive to their needs, which is reflective of all three of the models: Good Lives, 'Risk-Need-Responsivity' and 'What Works'.

In this study, all the focus groups highlighted the importance of the 'What Works' and 'Risk-Need-Responsivity' theories. Both of these theories positively argue that treatment and programmes with offenders should be responsive, so that offenders benefit from interventions that are meaningful to them and delivered in a way that is responsive to their needs and learning styles. Having a key worker who will develop a treatment plan that is responsive to an individual's needs is reflective of this.

The added value of this study is in obtaining the perspective of the patient and family groups, who are often excluded from research in this area. With regard to 'what works' and 'responsivity' in treatment, the patient/offender and family groups are clearly in agreement with these two psychological theories. Professionals also concur, stressing the need to persevere with treatment despite difficulties that might arise, and that such treatment should be proportionate to the patient's '*risk and need level*'.

Collaboration and Support

The professional and family groups agree on the need for better co-working relationships between forensic services and other teams. The patient group are of the opinion that professionals have positive working relationships with them. It is likely that the patients would not have the same exposure or insight to how professionals work compared to professionals and the family group. The need for positive collaboration and support is advocated by Ferguson (2002), who looked at 'What Works' from an organisational perspective. He emphasised the importance of strong commitment from professionals to the service delivery if it was to be a success.

Family Involvement and Support

All three groups emphasised the importance of the family in the risk management and treatment of mentally-disordered offenders. The family in particular advocated the need for a specific group tailored for them, with the purpose of increasing their insight to risk but also as a support mechanism; such a group does not exist at present. Professionals stressed the importance of involving families when working therapeutically with offenders. This is reflective of the 'Risk-Need-Responsivity' model where it is advocated that treatment should be tailored to the needs of the patient. An important, and what appears to be (from these findings) a 'lost' dimension, is support for the families of the patients who are often a critical factor in the risk management of a patient.

Psychological WellBeing

Therapeutic groups were emphasised as important in helping a patient's psychological wellbeing by the professional and patient groups. Professionals stated that groups are useful for managing '*difficult personalities*', whereas patients saw groups as being an important social outlet. This is reflective of the 'Good Lives' model where having a positive social network can help promote an offence-free life. However, professionals feel that more post-group follow-up work is required.

The family group highlighted differences between professionals and families as to what constitutes 'health and wellbeing'. They also stated that patients often hide mental health problems from professionals and thus there are differences in the 'reality and perception' between professionals and families as to what constitutes mental health problems. This is a key area for further exploration.

Public Perception and Awareness

All three groups agree that more education is required for the public to improve understanding on mental health issues. The family group, in particular, feel that people with forensic mental health are stigmatised by society. The professional group questioned whether society should take more responsibility, particularly when a person '*ends up in prison*'; has society failed them? These findings reflect elements of the 'Good Lives' and 'What Works' models, where community acceptance and reintegration is seen as an important factor in an offender's rehabilitation.

Living Environment

Both the professional and the family group agree that a patient's living environment is an important factor in their rehabilitation. This is reflective of the 'What Works' model, where treatment in the community (where deemed appropriate) is emphasised as more effective than if delivered in an institutional setting. This of course is dependent on the degree of support the individual has whilst living in the community, which in turn highlights the importance of support – such as the family – as evidenced in these findings.

Professional Characteristics

All three groups value the input of a specialist forensic team for mentally-disordered offenders. For the patient group, having a 'named key worker' appears to be important, highlighting the need for a professional person who is aware of, and responsive to, a patient's needs. This is reflective of the 'Risk-Need-Responsivity' and the 'What Works' models. For the family group, personal qualities, such as empathy and the ability to listen to an individual's concerns were stressed as important. The professional group emphasised the importance of being able to work assertively with challenging and difficult patients, and also highlighted the need for good co-working when treating this subject group. Appropriate training for professionals to meet these challenges is regarded as a priority.

Governance

All three groups highlighted the potentially negative rather than positive impact of governance arrangements. The patient group said they were aware of Trust

'cutbacks', and agreed that this impacted on their rehabilitation. The family group felt that resources and policies could be more focussed on a patient's needs, again reflecting the 'Risk-Need-Responsivity' and 'What Works' models. The professional group concurred with the view that adequate resources were important, that governance arrangements should reflect a '*whole systems*' approach, and that through better cross-disciplinary professional engagement and policy understanding an improved '*buy in*' to the direction and work of CFMHT would result. They also advocated that patients should not move straight from a secure facility, such as prison or hospital, to independent living in the community, but instead a more supportive approach should be offered in the transition process. This was an issue raised by professionals throughout the research process; it would require a change in governance arrangements.

4.6 Conclusion

The findings from the focus groups are generally supportive of the rehabilitative models, namely 'What Works', 'Good Lives', and 'Risk-Need-Responsivity'. However, there are specific areas that require further investigation. These include:

- The role of the key worker in a patient's risk management and treatment plan, and the professional characteristics identified as important in a key worker. This is reflected in research where the role of the therapeutic relationship is identified as a critical success factor in the treatment of offenders (Marshall et al., 1999). This also appears to be related to patient satisfaction. Crow, Storey, and Page (2003) argued

that there was consistent evidence across different settings suggesting that the most important health service factor affecting satisfaction is the patient/client relationship;

- What the three groups value from offending behaviour groups. It is clear from study one that the three groups highly value offending behaviour groups. Friendship et al.'s (2002) research states that in terms of recidivism those offenders who participate in cognitive behavioural offence focused groups are less likely to re-offend than those who don't. However, it would be interesting to determine the specifics of what the three groups value in studies two and three, through further exploration and a comparative analysis between the groups;
- The key elements of good co-working relationships. This is between professionals and multi-agency teams;
- The extent of stigma about mental health and what this means for a person's treatment and rehabilitation. Despite public education about mental health this still appears to be an issue for forensic mental health patients and their families and potentially has a negative impact on their engagement in treatment and rehabilitation. Byrne (1997) stated that campaigns to reduce stigma have to do more than increase knowledge of the stigmatised conditions;
- What we mean by psychological wellbeing and mental health in offender rehabilitation;
- The key elements of offender treatment from the perspective of the three groups.

CHAPTER 5: STUDY TWO
TREATING FORENSIC MENTAL HEALTH PATIENTS IN THE
COMMUNITY;
COMPARISON OF PATIENTS, THEIR FAMILIES, AND
PROFESSIONAL GROUPS

5.1 Introduction

Forensic mental health patients are a highly complex group and often present with multiple problems (addiction, personality disorder) as well as offending behaviour. Forensic patients frequently move through different levels of security, and ultimately to the community. The treatment of forensic mental health patients in the community needs to not only match the patient's assessed risks and needs but also their needs within their current environment. Study two explores the views of patients, families, and professionals with regard to the treatment of forensic mental health patients in the community under each of the ten themes identified in study one. The aims and objectives of study one are rephrased as hypotheses in study two.

The relevance of the research literature in relation to each of the ten themes in study two is briefly considered and set out below.

Risk Management

The 'Risk-Need-Responsivity' model (Andrews and Bonta, 1994) states that treatment intensity should be tailored to offenders' risk level and that those offenders assessed as high risk should receive more intensive treatment. Cognitive behavioural programmes adhering to the 'Risk, Need and

Responsivity' principles of risk management and treatment responsiveness appear to reduce recidivism. Mc Guire's (2000) meta-analyses reviewed the effectiveness of cognitive behavioural groups, showing a reduction in reconviction rates for those individuals who participated in the groups. Cognitive behavioural groups therefore appear to be an important treatment component in the risk management of forensic patients. This was first identified in study one through focus groups, and will be further explored in studies two and three.

A further important element in risk managing forensic patients is the role of the key worker. The results from study one highlighted this, and research in this area reinforces the importance of the therapeutic relationship in risk management. One of the key findings in Gerber and Price's 1999 study was that patients would like to spend more time with their key worker. This underlines the importance of the patient/professional relationship. Whether certain demographics such as age and gender have an impact on the therapeutic relationship will be explored in study three.

Treatment Interventions

Psycho-education and cognitive behavioural interventions appear to work well for forensic mental health patients. Cimino and Jennings (2002) evaluated a ten-week mental health education programme for male offenders in high-secure conditions. Overall, the participants gained more positive attitudes towards medication, which the authors deemed to be a positive outcome. The 'What Works' model states that treatment programmes should adhere to a number of principles, as outlined in Chapter 2. The results of study one indicated that all three groups (patient, family, and professional) value

cognitive behavioural groups as a treatment intervention in line with existing research in this area. Study two will explore what patients, families, and professionals perceive to be the key components of treatment for forensic mental health patients.

Treatment and Responsivity

Andrews and Bonta's (2003) responsivity principle in the 'Risk-Need-Responsivity' model states that all correction programmes should be matched to offender characteristics, such as learning style, motivation, and an individual's personal and interpersonal circumstances. Ward and Brown (2004) highlight a concern in the matching of treatment with offender characteristics. They advocate instead, that it should be ensured that offenders have the necessary competencies and values to engage in treatment, and that it should be delivered in a way that is directly responsive to individuals' particular learning styles and characteristics. Maguire (2002) states that cognitive skill programmes are an excellent example of readiness alongside motivational interviewing.

Collaboration and Support

The 'Risk-Need-Responsivity' model advocates that it is important that positive relationships with other agencies and organisations are developed when implementing treatment for offenders. 'Supervision' is a means of support for staff delivering offender treatment programmes. Clarke (2008) emphasises the importance of organisational support for people in 'critical occupations', for example, those persons who work with trauma, albeit directly through witnessing trauma at first hand or indirectly through listening to trauma accounts. Clarke identified individual resilience as the ability to cope with

witnessing or hearing such trauma; Paton, Violanti, Johnston, Burke, Clarke, and Keenan (2008) also discuss organisational resilience. They thus define resilience as the capacity of organizations and staff to 'draw upon their own individual, collective, and institutional resources and competencies to cope with, adapt to, and develop from the demands, challenges, and changes encountered during and after a critical incident' (p. 2). It would appear then that collaboration and support between, and for, staff working with offenders is an important consideration for organisations.

Living Environment

Cummins' (1996) research into wellbeing has identified important domains of life satisfaction, which reflect Ward's 'Good Lives' model 'primary goods' and the conditions required to benefit from treatment.

Being part of a community, and living in a community where a person feels integrated and supported is an important component of treatment and rehabilitation, (Ward and Brown, 2004). A person, therefore, needs to live in an environment where such changes are possible and supported. The existing research shows that the environment is of great importance in reducing risk factors and reaching the goal of a 'good life' (Incardi, Martin, and Surrat, 2001; Taylor, 2002). If a person is living in an environment where they are stigmatised, this will impact negatively on their treatment.

Family Involvement and support

Although the role of families in supporting forensic patients is seen as important, there is limited literature discussing the use of systemic work in forensic settings (Shelton 2010). However, as indicated in study one, family

interventions can be very important in some circumstances, such as managing risk and motivating offenders to engage in treatment.

Negative family relationships are identified as a major risk factor for recidivism in the 'Risk-Need-Responsivity' model. In the 'What Works' model, negative family factors are attributes, amongst others, that are associated with criminal behaviour and recidivism. Poor motivation to attend and engage in treatment is also an identified risk factor in the 'Risk-Need-Responsivity' model. In study one, all three groups identified the family as important in motivating offenders to engage in treatment. It would therefore appear prudent to provide support and offer education to families to assist in this very important role.

Psychological Wellbeing

Ward's 'Goods Lives' model stresses the importance of addressing non-criminogenic needs as well as criminogenic needs. For example, primary goods such as self-esteem, inner peace, happiness, and creativity could be related to psychological wellbeing. The pursuit and achievement of personal goals, in addition to achieving a sense of who they are, and who they would like to become, appears to be an important consideration when treating offenders (Bruner, 1990; Singer, 2005). Ward and Brown (2004) state that when treating forensic mental health patients we need to promote pro-social and personally satisfying goals. Therefore, attending to the offender in a holistic way, which specifically includes enhancing psychological wellbeing, is an important component of offender treatment.

Public Perceptions and Awareness

Research has demonstrated that the media and personal experience/knowledge of crime plays an important role in shaping public

perceptions of the crime problem (Davidson 2008; Sewkes 2004; Mohan, Twigg, and Taylor, 2011; Reiner, 2007). This can distract the public from fully appreciating the complexities of offending behaviour and mental health, and result in misleading presentation of both behaviours. This in turn has implications for the success of treatment and prevention efforts.

A number of studies have focused on public perceptions towards the manner in which sex offenders are dealt with by criminal justice agencies. Most of them demonstrated a punitive attitude towards sex offenders (Brown, Declein, and Spencer, 2008; Levenson, Brannon, and Baker, 2007).

Stigma and negative attitudes towards offenders may be a barrier to effective treatment and rehabilitation. The 'Risk-Need-Responsivity' model identifies lack of involvement in pro-social, recreational, and leisure activities as a risk/need factor. In order for offenders to be integrated into the community the public may require education on how to work best with this group. Ward and Brown (2004) suggest that unless offenders are treated by people as valuable human beings, which increases the likelihood of them being able to accept and forgive themselves for the crime they have committed, behavioural change is less likely. Overcoming stigma appears to be a critical success factor for treatment.

Professional Characteristics

Ward and Brown (2004) state that motivating offenders and creating a sound therapeutic alliance are pivotal components of effective treatment, and are as important as the illustration of strategies and techniques. They go on to say that therapists' attitudes towards offenders are critical in successful treatment

outcomes. They state it is important for therapists to be non-judgemental and to convey respect for the offender. Marshall, Fernandez, Serran, Mulloy, Thornton, and Mann (2003) have concluded that increasing self-esteem, working collaboratively with offenders in developing treatment goals, and the cultivation of therapist features such as displays of empathy and warmth, and encouraging rewards for progress, all facilitate the change process in sex offenders. Their view is in agreement with Ward and Brown (2004) in that it is much easier to achieve such goals if the therapist has a positive view about the offender. The 'Good Lives' model fits well with this approach as it is based on a more positive view of human nature and the intrinsic value of human beings.

Governance

Adherence to 'Risk-Need-Responsivity' principles provided a context within which organisations can adhere to integrity standards in terms of how treatment programmes can be delivered to forensic patients with mental health needs. According to Andrews and Dowden (2005), increased programme integrity and better staff practice can improve treatment outcomes. It is therefore important that the right structures and governance arrangements are in place to facilitate this.

The principles of the 'Risk-Need-Responsivity' model also advocate that managers need to select and train staff well, ensuring that there is clinical supervision and organised mechanisms to maintain the monitoring, evaluation, and integrity of risk assessments and treatment programmes. This is also reflective of Marshall et al. (2003) and Ward and Brown (2004), who strongly advocate the importance of the therapeutic relationship and alliance

when working with offenders. A good governance arrangement, particularly around the training and supervision of staff, seems to be critical to successful treatment.

Summary

There is an extensive body of literature on offender treatment and rehabilitation. However, most of this pertains to offenders in the criminal justice system. Less is known about what works in the community and even less about what works from the perspective of offenders themselves. In summary, the research shows that cognitive behavioural-based treatments work best with offenders in terms of recidivism and wellbeing (Friendship et al. 2002, 2003). Less research has been conducted with regard to what works best in terms of psychological-based interventions for forensic patients with a diagnosed mental illness. The general assumption appears to be that cognitive behavioural interventions can be adapted and delivered to forensic mental health patients (Gudjonsson, Young, and Yates, 2007).

What also appears to reduce recidivism in terms of offender treatment is addressing non-criminogenic needs. So for example, psychological wellbeing (self-esteem, anxiety) and considering where the person lives; these factors appear to be just as important as targeting anti-social criminal attitudes (Ward and Brown, 2004). Finally, how treatment is delivered is important. The therapist's attitude to the offender, and how they see and value the person are all critical in influencing a successful outcome, (Marshall et al. 2003; Ward and Brown, 2004).

5.2 Aim and Hypothesis

The aims and objectives for study one were rephrased as hypotheses in study two.

Aim: To compare the perspectives of patients, families, and professionals, in terms of the treatment interventions and rehabilitative models delivered for patients in the community. **Hypothesis:** It is hypothesised that there will not be significant differences between the three groups' perspectives in terms of treatment for forensic mental health patients.

Aim: To compare how satisfied offenders and their families are with the community forensic service; the value they place on the service and their understanding of the current approaches and rehabilitative models that have been adopted and applied. **Hypothesis:** It was hypothesised all the three groups would report satisfaction with the service received from the Community Forensic Mental Health Team.

Aim To explore the relationship between the therapist and the offender. **Hypothesis:** It was hypothesised that all three groups would identify the importance of a strong therapeutic relationship between therapist and offender for treatment intervention and risk management.

Aim: To explore the legacy of the troubles in Northern Ireland on the treatment and rehabilitation of offenders and their families. **Hypothesis:** It was hypothesised that all three groups would report a negative impact from the 'troubles' on the treatment and rehabilitation of mentally-disordered offenders receiving a service from a CFMHT in Northern Ireland.

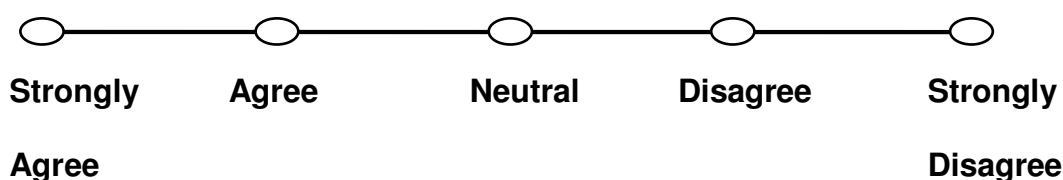
Within each theme there are individual hypotheses related to the research questions; these will be stated when describing the results. The aim was to test the hypotheses and also assess and build on the ten themes and evolving model that emerged in study one.

The key objective of this study was to compare potential differences in attitudes between the three groups concerning what works best in terms of rehabilitative models and forensic treatment interventions, and to draw out differences in the three service user groups' perspectives.

5.3 Methodology

Design

Questionnaires were formulated using the analysed data from the focus groups described and evaluated in study one. Three versions of a questionnaire (one for staff, one for clients, and one for their families) were designed on the basis of the ten themes derived from the previous focus group-based study. This provided a meaningful order and format, and a coherent framework to construct the statements (questions) and the subsequent analysis of data. A 1 to 5 Likert Scale ranging from 'strongly agree' to 'strongly disagree' was used as the response method (Likert, 1932). The scale was 'treated' as if it was a 1-5 scale with the higher scores indicating stronger disagreement and lower scores stronger agreement with a statement. The scale was presented as follows:



The questionnaire began with a consent form to ensure participants were fully informed as to the purpose of this stage of the research. An information sheet relating to the completion of the questionnaires was included. A set of questions seeking to elicit demographic information was presented prior to the research questions. Each questionnaire was ascribed a unique ID Code for identification and confidentiality purposes. Copies of the questionnaires are set out in Appendices 12, 13, and 14.






The questionnaires included a series of statements which were designed to be the same for each group, although the language was simplified for the patient group to accommodate their cognitive ability. There were a total of 37 research questions/statements, however, two of these were excluded for family members, and three were excluded for patients due to their specific lack of relevance for these groups.

This design approach, making appropriate use of the focus group outcomes, helped identify specific research areas where detailed questionnaire exploration would be of benefit. An example was under the 'treatment intervention' theme to find out what works for treatment of forensic patients in the community. On this basis the content of the research questions was constructed to ensure a meaningful group comparison could be made between data produced by the three groups.

Under each theme a number of discretionary questions were included to provide the respondents with an opportunity to express additional views.

To further aid understanding for the patient group, and to ensure these participants accurately rated the research questions, picture symbols were

provided, which represented the Likert scale from 'strongly agree' to 'strongly disagree' as follows:

1.1 Role of the Key Worker: Research Questions Statements	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
	1 	2 	3 	4 	5 
1. My forensic key worker plays an important role in my risk management and treatment plan					

(See Appendix 12 for a copy of the above questionnaire.)

Subject group Profiles

All of the three subject groups were heterogeneous; their profiles are detailed in the following tables. Those who participated in study one, the focus groups, also participated in this study.

Table 1: Patient Group

Gender	Diagnosis	Offence	Age
Male	Personality Disorder	Sex Offending	25
Male	Depression	Sex Offending	22
Male	Depression	Sex Offending	29
Male	Bipolar	Violent	20
Male	Personality Disorder	Violent	41
Male	Depression	Violent	23
Male	Bipolar	Drugs/Alcohol	40
Male	Depression	Sex Offending	27
Male	Depression	Sex Offending	22
Male	Addiction	Violence	42
Male	Depression	Drugs	28
Male	Paranoid Schizophrenia	Violence	25
Male	Paranoid Schizophrenia	Violence	22
Male	Paranoid Schizophrenia	Violence	39
Male	Paranoid Schizophrenia	Violence	36
Male	Paranoid Schizophrenia	Violence	32
Male	Paranoid Schizophrenia	Violence	28

Male	Paranoid Schizophrenia	Violence	45
Male	Paranoid Schizophrenia	Violence	34
Male	Paranoid Schizophrenia	Violence	37
Male	Paranoid Schizophrenia	Violence	38
Male	Paranoid Schizophrenia	Violence	22
Male	Paranoid Schizophrenia	Drugs	25
Male	Paranoid Schizophrenia	Sexual	33
Male	Paranoid Schizophrenia	Violence	21
Male	Paranoid Schizophrenia	Violence	39
Male	Paranoid Schizophrenia	Violence	34

Mean age: 30

Table 2: Family Member Group

Gender	Relationship to Patient	Age
Female	Wife	31
Female	Wife	32
Male	Brother	45
Male	Father	69
Male	Father	60
Female	Mother	55
Female	Mother	61
Female	Mother	50
Female	Sister	33
Female	Mother	55
Female	Mother	52
Female	Mother	63
Male	Father	56

Mean age: 51

Table 3: Professional Group

Gender	Profession	Age
Female	Social Worker	41
Female	Police Officer	56
Male	Police Officer	52

Female	Psychologist	54
Male	Psychiatrist	50
Male	Psychiatrist	49
Male	Nurse	43
Male	Social Worker	32
Male	Forensic Psychologist	29
Female	Nurse	26
Male	Nurse	33
Female	Nurse	41
Female	Nurse	43
Female	Nurse	34
Female	Nurse	32
Female	Social Worker	32
Male	Social Worker	37
Male	Police Officer	37
Male	Police Officer	30
Male	Police Officer	44
Male	Police Officer	41
Male	Police Officer	28
Female	Nurse	30
Male	Psychologist	35
Male	Police Officer	40
Female	Nurse	34
Female	Nurse	45

Female	Nurse	27
Female	Nurse	42
Female	Social Worker	43
Male	Forensic Practitioner	40
Male	Forensic Practitioner	41
Male	Forensic Practitioner	49
Male	Manager	50
Female	Probation Officer	43
Female	Probation Officer	33

Mean age: 39

5.4 Procedure

a) Pilot Group

The questionnaire was piloted with a participant from each group. Some minor changes were made as a result. This related to the wording of some of the research questions to ensure they were better understood by the participants.

b) Questionnaire Administration

In the case of the family and patient groups the questionnaire was administered on an individual, face-to-face basis. This system improved the engagement of the participants and removed the possibility of misunderstanding. At the outset, patients were assured that their responses would be recorded anonymously, thus complying with the confidentiality agreement in their consent forms and the research in general. Thirty-seven patients were approached and twenty-seven agreed to participate. Thirteen

family members were approached and they all agreed to complete the questionnaires.

With regard to the professional group, questionnaires were posted to each professional in a stamped addressed envelope for return by a given date. Follow-up telephone calls were made to help secure a satisfactory response rate. A total of fifty-seven questionnaires were posted and eighteen were returned. A higher number than required were posted to ensure a reasonable return rate.

A total of ninety-seven questionnaires were either posted or administered. Fifty-eight questionnaires were completed, a response rate of 59%.

c) *Data Collation*

The returned questionnaires were separated into the three groups (patient, family, professional), and the data from the Likert scales in response to the research questions were processed using SPSS Statistical Analysis and inputted using assigned codes (as detailed in Appendices 16 and 17). The completed data provided the basis for the detailed statistical analysis. Each statement in the questionnaire was assigned an identification code, for example, two research questions: *My forensic key worker plays an important role in my risk management and treatment plan* was assigned *RM1*, and *The gender of my forensic key worker influences my risk management and treatment* was assigned *RM2*, etc.

One-way ANOVA was selected to compare the means of the groups in order to make inferences about the population means; that is, family, patient, and

professional, and post-hoc comparisons of means undertaken. (See Appendices 17 and 18).

5.5 Results

The questionnaires were developed according to the methodology and process above; they are detailed in Appendices 12-14; Appendix 18 summaries the results and leads to the development of the questions for the semi-structured interviews in study three.

The findings are set out below in the tables under each of the ten themes detailing the results from the one way ANOVA and post-hoc comparison of means related to each research question. Bar charts of means for each of the ten themes are also included.

Theme 1: Risk Management (RM)

Full details of the results (means, standard deviations, F and p values) are presented in Table 1 below. The main findings are summarised in the following sections.

Research Question One (RM1): My forensic key worker plays an important role in my risk management and treatment plan ('Risk-Need-Responsivity' model)

It was hypothesised that all three groups would endorse the importance of the key worker. Marshall et al. (2003), Ward (2002), and Ward and Brown (2004), emphasise the importance of the patient-therapist relationship in offender rehabilitation and identify qualities such as warmth, empathy, and integrity as being particularly significant.

The role of the key worker in a patient's risk management was identified as important in the previous study outlined in Chapter 4. On the basis of those findings it was hypothesised that all three groups would endorse the importance of the key worker, but this would particularly be the case for the patient and family groups.

A one way ANOVA indicated that there was a statistically significant difference between the three groups ($F = 8.9$; $p < 0.001$). Post-hoc comparisons of means indicated that the family group (1.08) was more likely to agree with the importance of the key worker role than either the patient (1.67) or staff groups (1.19).

Research Question Two (RM2): The gender of my forensic key worker influences my risk management and treatment

A strong therapeutic alliance is imperative in order to achieve a successful outcome in offender rehabilitation. Research indicates that patients who do not feel this alliance due to gender, age, cultural, or religious differences were more likely to terminate treatment as early as the first session, (Rosen, Miller, Nakash, Halpern, and Alegria, 2012). Even though study one did not identify this as an important issue given the research evidence it was tested in study two.

It was hypothesised, given the results from study one, that gender would not be a significant factor in influencing risk management and treatment. A one way ANOVA indicated that the groups did not differ from each other ($F = 1.2$; ns).

Research Question Three (RM3): The age of my forensic key worker influences my risk management and treatment

It was hypothesised that age would not be a significant factor in influencing risk management and treatment as this was not an identified issue in study one, the focus groups. However, Rosen et al.'s (2012) research, which assessed 114 videos of intake sessions between therapists and clients, indicated that clients who were matched with therapists close in age developed a stronger bond at intake. They went on to say this could be due to the fact that people of the same age view life events with a similar perspective, and have similar ideals.

A one way ANOVA indicated that there was a significant overall variation between the three groups with regard to their view that the age of the key worker influences risk management and treatment ($F = 3.3$; $p < 0.05$). However, a post-hoc comparison of means indicated that although the professional group were less likely to agree with this statement, each individual group did not differ significantly from each other.

Research Question Four (RM4): The religion of my key worker influences my risk management and treatment

It was hypothesised that religion would not be a significant factor in influencing risk management and treatment as this was not identified as an issue in the focus groups in study one. However, Wikler (1989), who conducted semi-structured in-person interviews with a sample of Orthodox Jewish clients of outpatient mental health clinics and private practitioners, found a wide range of diverse meanings attached to the therapist's religious identity by Orthodox

Jewish clients. This suggests that religious differences in the therapeutic relationship can, and do, play a critical role in the treatment process. Given the cultural and religious tension present in Northern Ireland it was felt that this issue was worthy of investigation.

A one way ANOVA indicated that there was no significant overall variation between the three groups with regard to the view that religion is an influencing factor on the role of the key worker with regard to risk management and treatment ($F = 0.89$; ns).

Research Question Five (RM5): Risk assessment and treatment plan is important ('Risk-Need-Responsivity' model)

It was hypothesised that professionals would endorse this statement to a greater extent than would be the case for families and patients. The 'Risk-Need-Responsivity' model indicates that risk assessments and treatment plans should be interlinked. In the previous study all three groups viewed a patient's risk assessment and treatment plan as important. However, there was a difference in how this was interpreted by the groups. The patient and family group were focused on individual needs, whereas the professional group emphasised the importance of the process of risk management, ensuring all elements of a risk assessment are covered.

A one way ANOVA indicated that the groups did not differ from each other ($F = 3.9$; ns).

Research Question Six (RM6): Being risk-averse has a negative impact on risk management and patient rehabilitation

Being risk-averse was an issue raised in the previous study, where it was stated (by professionals) that too much emphasis on risk management can foster defensive, 'risk-averse' practice. Ward et al.'s (2007) 'Good Lives' model criticises the 'Risk-Need-Responsivity' model for being too focussed on assessing and treating criminogenic needs. Ward states that it is also important to look at an individual's strengths, primary goods and motivations rather than purely focusing on risk. The results of study one appear to reflect this, where professionals state that too much emphasis on risk can lead to therapists overlooking the person and their rehabilitation.

It was hypothesised that professionals would be more likely to endorse this statement than the family group.

A one way ANOVA indicated that there was a significant overall effect regarding the negative impact of being risk-averse on risk management and rehabilitation ($F = 7.2$; $p < 0.01$) with the family group more likely to disagree (2.62) than the professionals (1.86).

Research Question Seven (RM7): The NI culture and high awareness of equality influences my risk management plan

Given the religious/political divide in Northern Ireland and the influence of this on offending it was felt that this was an important area to examine. Previously research has established that the prolonged conflict in Northern Ireland has had an adverse effect on the mental health and wellbeing of citizens (O'Reilly and Stevenson, 2003). The study by O'Reilly and Stevenson went on to say that those living in disadvantaged circumstances were much more likely to rate an impact of the Troubles on their lives, and that the hostility and distrust

inherent in conflict might affect an individual's sense of wellbeing and control. Patients and families participating in this study were largely from socio-economically-deprived communities. By virtue of this, in addition to self-reported ongoing exposure to paramilitary-style activities in their area, this group may rate the Northern Ireland culture as having a negative impact on their mental health and ability to benefit from treatment.

A one way ANOVA indicated that there was a statistically significant difference between groups ($F = 11.5$; $p < 0.001$). Post-hoc comparisons of means indicated that the professional group (2.17) were more likely to endorse this item than either the patient (3.15) or family (3.15) groups.

In summary, the results relating to risk management indicate that family group is more likely to agree with the importance of the key worker role than either the patient or professional groups, but that the religion, age, and gender of a key worker do not influence evaluations of risk management or treatment. Professionals are more likely to agree that being risk averse impacts on rehabilitations, as does NI culture, and being aware of inequality.

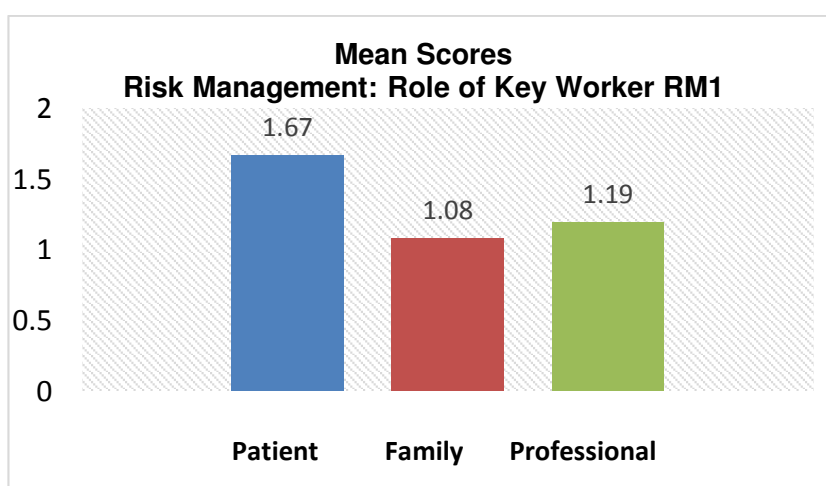
Table 1

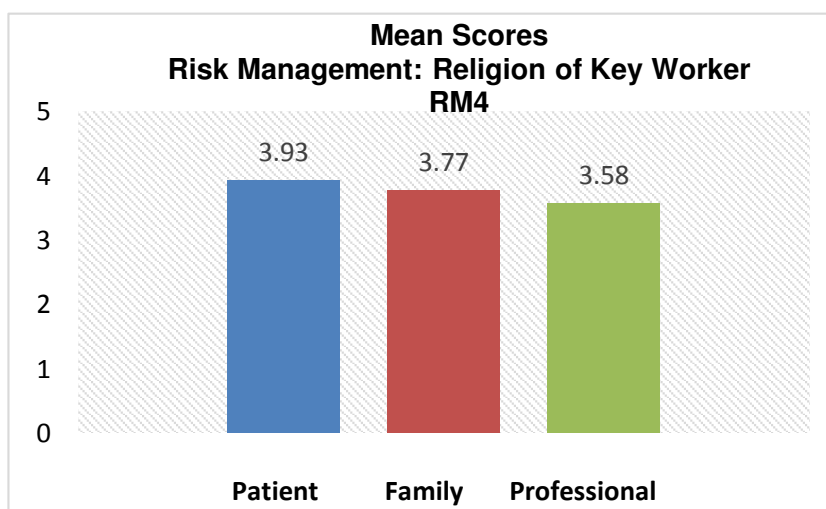
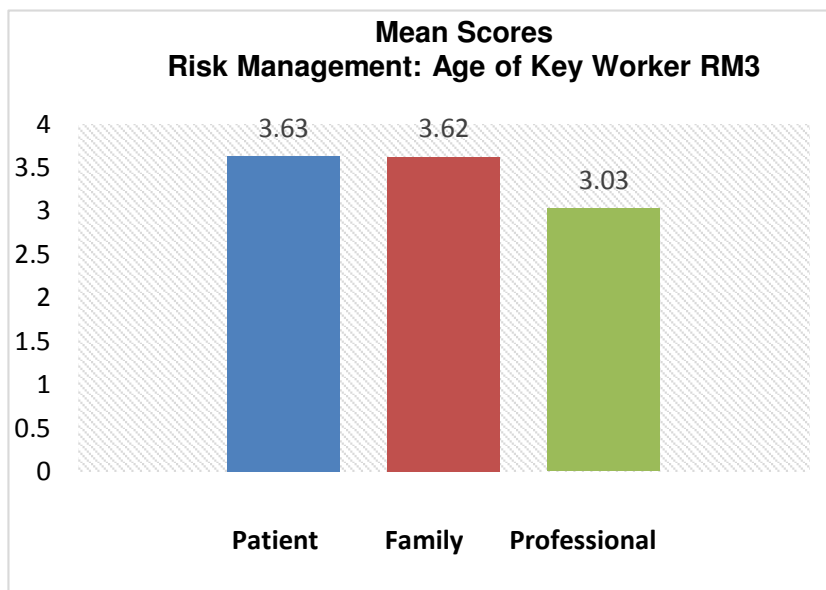
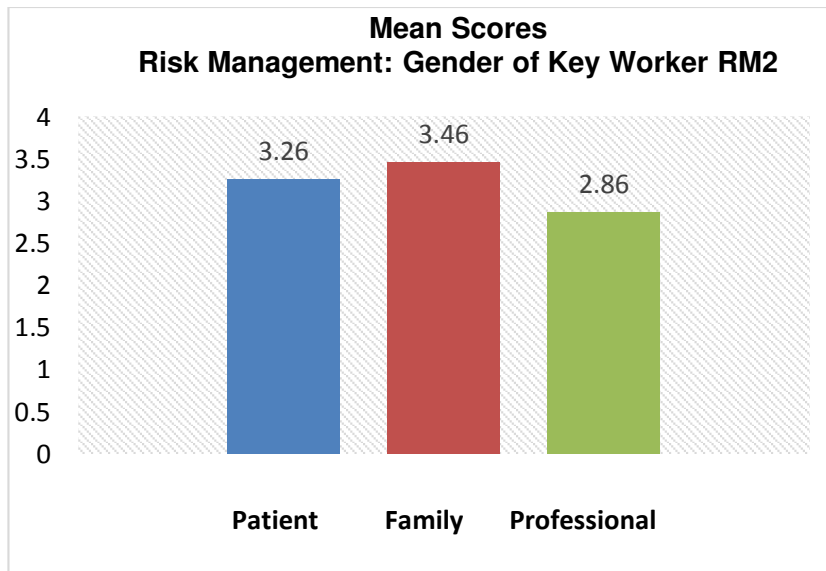
RM – Risk Management

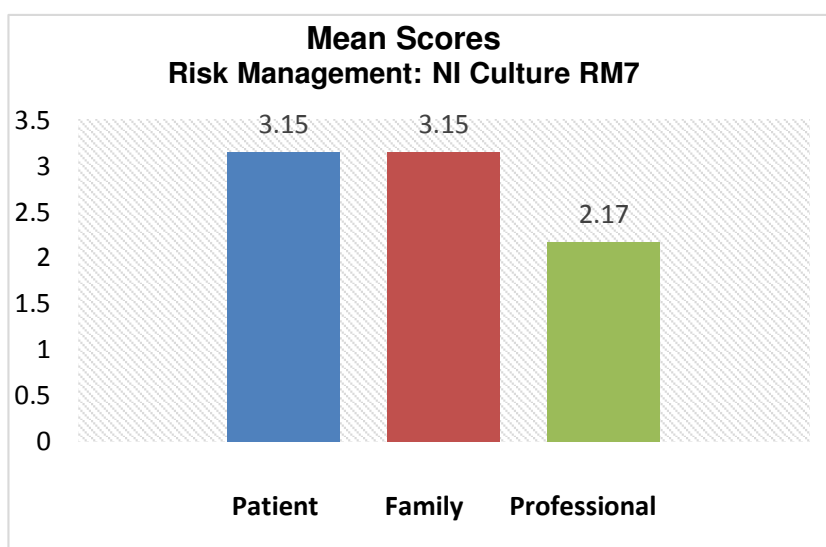
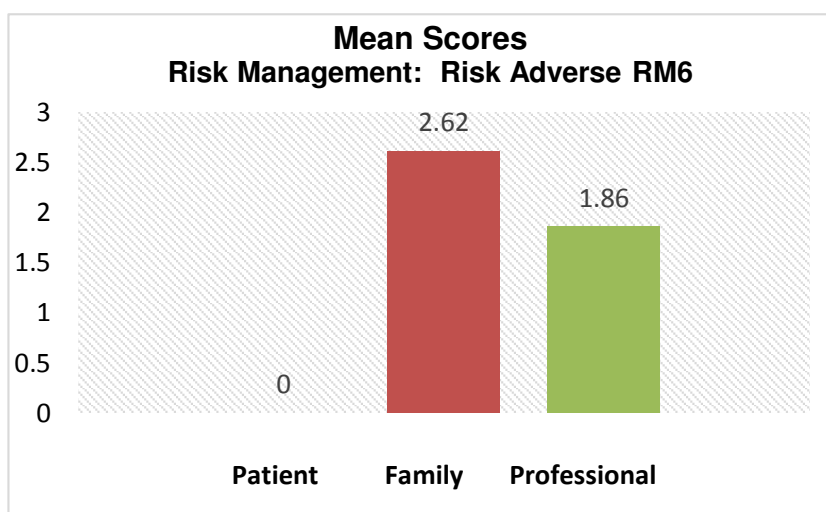
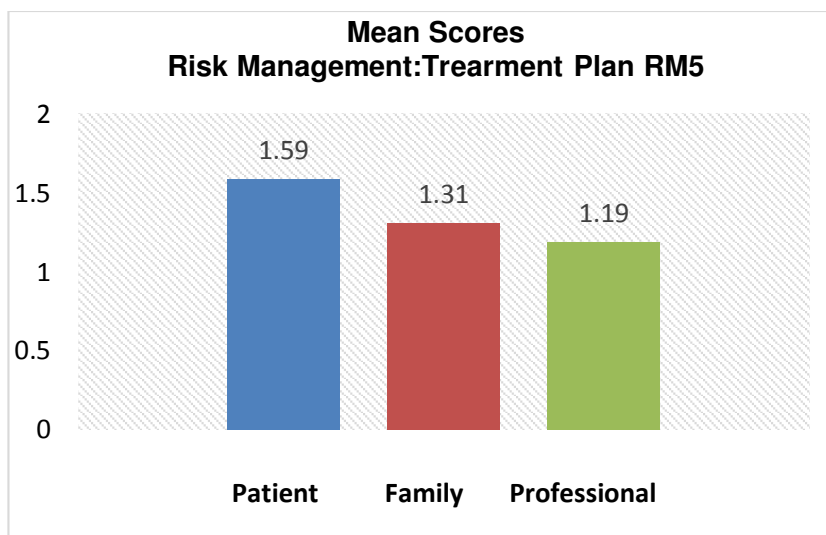
RM	Patient		Family		Professional		F	P
	MEAN	SD	MEAN	SD	MEAN	SD		
RM1 Role of Key Worker	1.67	0.620	1.08	0.277	1.19	0.467	8.934	0.00
RM2 Gender of Key	3.26	1.130	3.46	1.127	2.86	1.099	1.785	0.175

Worker								
RM3 Age of Key Worker	3.63	0.894	3.62	1.193	3.03	1.038	3.319	0.042
RM4 Religion of Key Worker	3.93	0.917	3.77	1.092	3.58	1.052	0.890	0.415
RM5 Treatme nt Plan	1.59	0.694	1.31	0.480	1.19	0.467	3.950	0.23
RM6 Risk- averse	-	-	2.62	1.044	1.86	0.798	7.218	0.010
RM7 N. I. Culture	3.15	0.949	3.15	0.987	2.17	0.811	11.510	0.00

Bar charts for Means of Risk Management Theme







Theme 2: Treatment Interventions (TI)

Full details of the results (means, standard deviations, F and p values) are presented in Table 2 below. The main findings are summarised in the following sections

Research Question One (TI1): Patient participation in forensic therapeutic groups is important for an individual's mental health, social well-being and risk of offending ('What Works' model)

Forensic therapeutic groups were advocated as an important treatment intervention in the previous study. Previous research has established the importance of cognitive behavioural groups in the treatment of offenders. Research by Andrews et al (1990) indicates a reduction of up to 50% in reoffending for those who participate in psychologically appropriate treatment. Friendship et al (2002, 2003) found that cognitive skills programmes for offenders in prison reduced reconviction by up to 10%. McGuire (2002) stated that structured programmes can attain an average of 40% reduction in recidivism in community settings and 30% reduction in institutional settings.

It was hypothesised that all three groups would endorse this statement emphasising that forensic groups are important.

A One way ANOVA indicated that the groups did not differ from each other ($F = 0.480$; ns) with regard to their view that patient participation in forensic therapeutic groups is important for an individual's mental health, social well-being and risk of offending.

Research Question Two (TI2): Having a purposeful and fulfilled life plays an important role in preventing a person from re-offending ('Good Lives' model)

Ward's 'Good Lives' model (2002) is described as a way of living that is fulfilling, meets basic human needs, and takes account of the individual's interests, skills, temperament, abilities, and support networks. Simon et al. (2008) found that a Good Lives focus in treatment with offenders resulted in significantly lower rates of attrition and higher levels of motivation compared to treatment using the standard Relapse Prevention model. It was hypothesised that all three groups would endorse the view that having a purpose and a fulfilled life is important, and that this should be addressed in treatment. This was strongly endorsed in the focus group data. Specifics of this are further explored by interview in study three.

A one way ANOVA indicated that the groups did not differ from each other ($F = 3.308$; ns).

Research Question Three (TI3): The 'Troubles' in Northern Ireland has had a negative impact on patient rehabilitation

As previously mentioned, research by O'Reilly and Stevenson (2003) indicated that prolonged exposure to the fear of injury, death, or bereavement might well lead to anxiety and distress in vulnerable people, even if in statistical terms their risk exposure is small. Smyth, Fay, and Brough (2004), who looked at the impact of troubles on young people, indicated that certain geographical areas of Northern Ireland and subpopulations (deprived working-class communities)

have been more affected than others. In this study the majority of patient and family groups live in deprived working-class communities, and reported having been affected by ongoing paramilitary activity in their community. It was hypothesised that because of this they may not benefit from treatment as well as they should. Also, there may be possible variation in the professional group between professionals working in the criminal justice system who may have had more exposure to the Troubles compared to health care workers.

A one way ANOVA indicated that the groups did not differ from each other ($F = 1.644$; ns).

Research Question Four (T14): A support group for families of patients with forensic mental health needs would be beneficial ('What Works' model)

It was hypothesised that all three groups would endorse this statement with the probability that it would be of more significance for the family group, given that they raised this as important in the focus group data. The Bamford review NI (2006) states that the needs of carers/families must be addressed. They note that carers have experienced difficulties understanding the nature of service users' problems, and providing appropriate support. As a result they have become alienated. They therefore require assessment of their own needs and provision of necessary information and support.

A one way ANOVA indicated that the groups did not differ from each other ($F = 2.627$ ns).

Research Question Five (TI5): In treatment there should be equal focus on offending needs, mental health needs, and the development of life skills ('Good Lives' model)

It was hypothesised that all three groups would endorse this statement, with the family and patient groups likely to place more emphasis on its importance. Ward and Brown's (2003) research highlights the importance of looking holistically at the person in offender treatment. They critique the 'Risk-Need-Responsivity' model for being too focussed on criminogenic needs and state that both criminogenic and non-criminogenic needs should be addressed to effect change. The Bamford Review NI (2006) also discusses the importance of treating each person as a respected individual and that professionals should address the wide range of problems specific to each individual to help integrate them back into society.

A one way ANOVA indicated that the groups did not differ from each other ($F = 0.592$; ns).

Research Question Six (TI6): There should be a 'stepped down' facility between secure environment and community living for forensic patients ('What Works' model)

It was hypothesised that the professional group would be the only group to endorse this statement. In the previous study the professionals had the most to say on this subject, strongly advocating the need for such an approach. The Bamford Review (NI) (2006) advocates the need for a seamless transition from secure to community living and that people should be supported to ensure the

timely discharge from secure inpatient services to appropriate accommodation in the community. This is also reflective of the Reed Principles (1992), which stated that people with forensic mental health needs should be treated under conditions of no greater security than is justified by the degree of danger they present to themselves or others, and as far as possible they should be treated in the community rather than in institutional settings.

A one way ANOVA indicated that there was a statistically significant difference between groups ($F = 10.632$; $p < 0.001$). A post-hoc comparison of means indicated that the professional group (1.64) were more likely to agree with the need for a stepped-down facility compared to the patient (2.63) and family (2.15) groups.

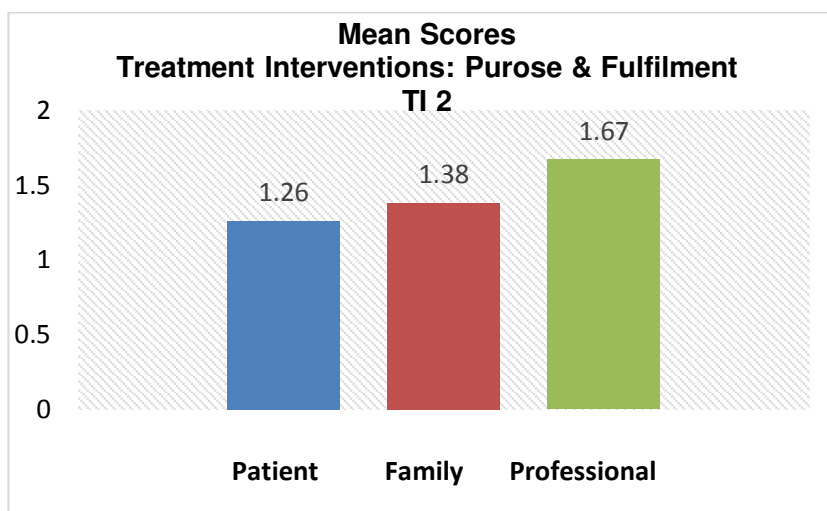
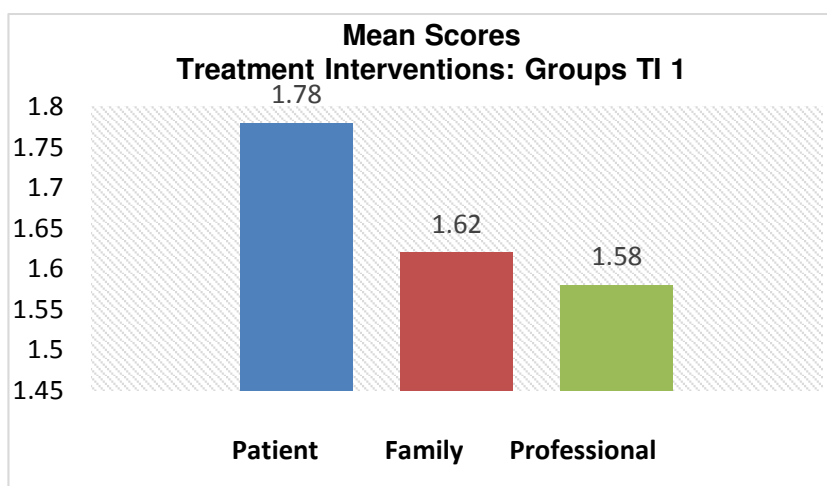
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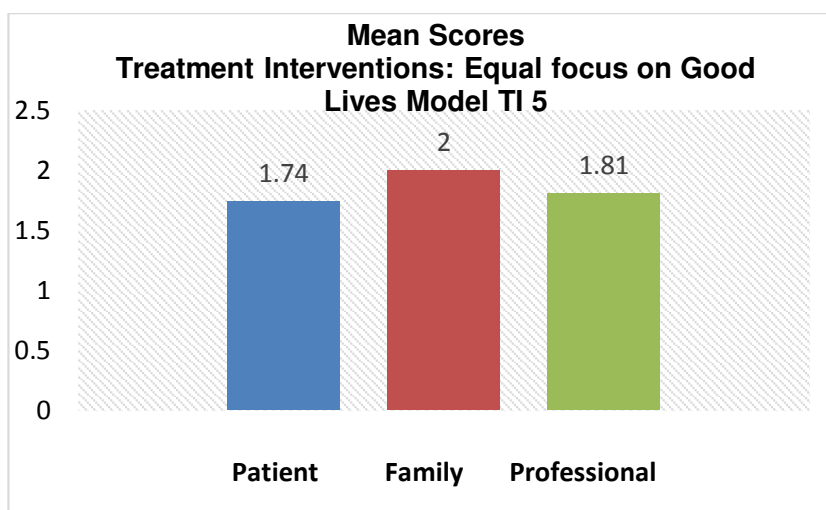
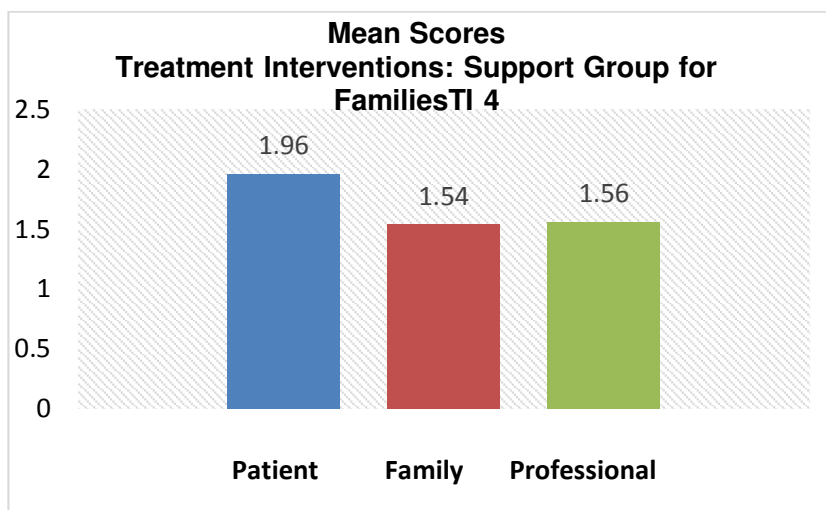
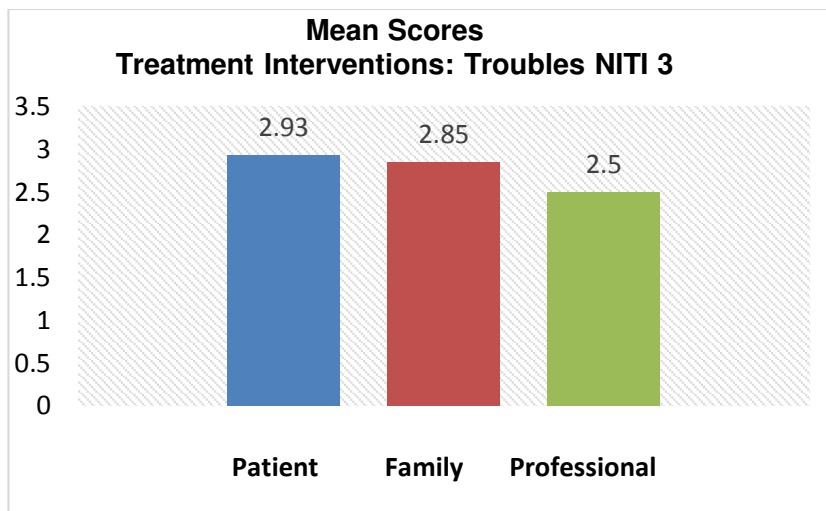
TI-Treatment Intervention

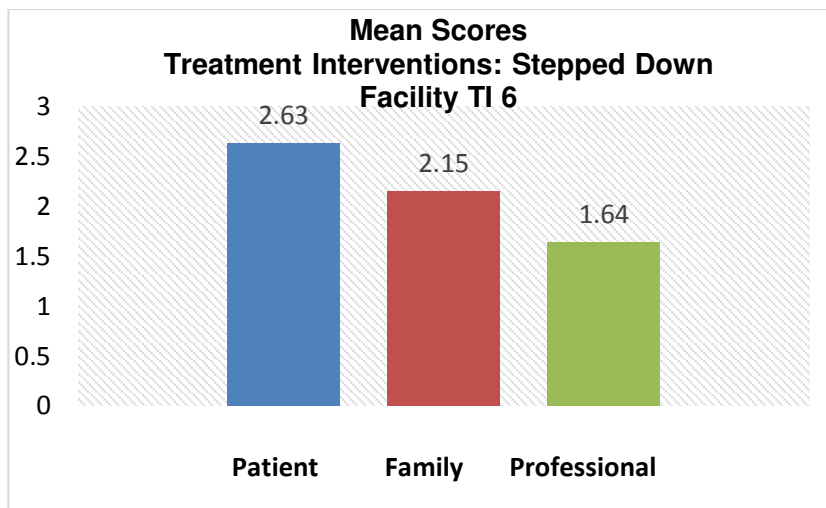
TI	Patient		Family		Professional		F	P
	Mean	SD	Mean	SD	Mean	SD		
T11 Groups	1.78	0.934	1.62	0.768	1.58	0.692	0.480	0.621
T12 Purpose & Fulfilment	1.26	0.447	1.38	0.506	1.67	0.828	3.038	0.054
T13 Troubles NI	2.93	1.107	2.85	0.987	2.50	0.845	1.644	0.200
T14 Support Group for families	1.96	0.898	1.54	0.660	1.56	0.652	2.627	0.079
T15	1.74	0.813	2.00	0.577	1.81	0.668	0.592	0.556

Equal Focus on Good Lives Model								
TI6 Stepped Down Facility	2.63	1.006	2.15	0.899	1.64	0.683	10.632	0.000

Bar Charts for Means of Treatment Intervention Theme







Theme 3: Treatment Responsivity (TR)

Full details of the results (means, standard deviations, F and p values) are presented in Table 3 below. The main findings are summarised in the following sections.

Research Question One (TR1): The forensic patient's family plays an important role in motivating and encouraging a person to engage in treatment ('Risk-Need-Responsivity' model)

The previous study indicated that all three groups felt that treatment should be responsive to an individual's needs. One of the core elements of Andrew and Bonta's (1994) 'Risk-Need-Responsivity' model is the notion of responsivity. This advocates that treatment should be responsive to the needs of the offender and is delivered in a way that is meaningful and makes sense. For some individuals the family may be an important motivator in encouraging people to engage in treatment. Research by Briggs and Turner (2005), relating to offenders participating in a drug treating and testing order

through the National Probation Service, indicates that family can be a motivational factor for wanting to get clean from drugs and thus motivates offenders to do well on the drug treatment and testing order. Family can also give additional support to that which is provided by staff. Turner (2004) reports changes in offenders' views on the importance of their relationships, and the effort they put into maintaining their relationships at the 6-month stage of treatment. Andrews and Bonta (1994) say that treatment plans should be tailored to consider issues such as the role of the family, in order to be the most effective.

It was hypothesised that all three groups would endorse this statement with the family group more likely to do so than the other two groups.

A one way ANOVA indicated that there was an overall statistically significant difference between groups ($F = 4.015$; $p < 0.05$).

Research Question Two (TR2): Professionals have an important role to play in motivating a person to engage in treatment ('Risk-Need-Responsivity' model)

It was hypothesised that all three groups would endorse this statement. Research exploring the role of motivation in offenders by Ward et al. (2007) emphasises the importance of the therapeutic alliance between professional and patient, particularly in offender rehabilitation programmes. Marshall et al. (2003) identified the development of an effective therapeutic alliance as essential to effective sexual offender treatment, and many effective

treatments for personality disorder also emphasise the importance of the alliance (Benjamin and Karpiak, 2001).

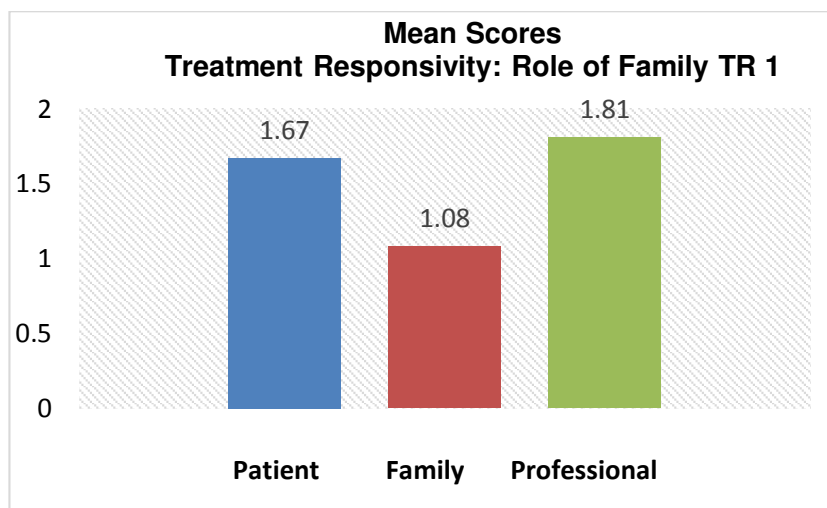
A one way ANOVA indicated that the groups did not differ from each other ($F = 3.036$; ns). Those differences which do exist between the three groups are explored through the semi-structured interview in study 3.

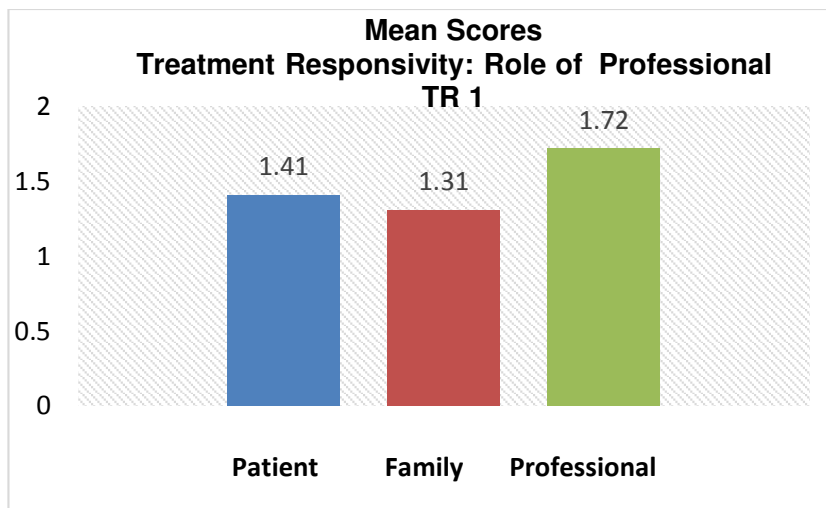
Table 3

TR - Treatment Responsivity

TR	Patient		Family		Professional		F	P
	Mean	SD	Mean	SD	Mean	SD		
TR1 Role of Family	1.67	0.961	1.08	0.277	1.81	0.786	4.015	0.022
TR2 Role of Profs	1.41	0.572	1.31	0.480	1.72	0.701	3.036	0.054

Bar Charts for Means of Treatment Responsivity Theme





Theme 4: Collaboration and Support (CS)

Full details of the results (means, standard deviations, F and p values) are presented in Table 4 below. The main findings are summarised in the following sections.

Research Question One (CS1): Transition services between the hospital and the community for forensic patients need to be improved upon ('What Works' model)

It was hypothesised that professionals would endorse this statement. However, it was also predicted that the patient and family groups would not be aware of problems in this area.

The Northern Ireland Bamford Review (2006) emphasises the importance of teams working together effectively, particularly in the resettlement of patients from security to community. The review also highlights that services should be developed in partnership with all relevant parties and that there should be

an adequate number of places, and quality of service, to allow service users to be placed in good quality accommodation. Furthermore, this should be according to their needs rather than the availability of a place. This echoes both the 'Good Lives' model and the 'Risk-Need-Responsivity' model, which emphasises the importance of being responsive to the needs of the individual.

A one way ANOVA indicated that there is a statistically significant difference between groups ($F=11.065$ $p < .001$) A post-hoc comparison of means indicated that the patient group (3.15) were more likely to disagree with the statement than the family (2.15) ($p < 0.001$) and professional (1.97) ($p < 0.001$) groups.

Research Question Two (CS2): The forensic team need to increase awareness of the service and what they do

It was hypothesised that the professionals would endorse this statement but that the patient and family groups would not be aware of problems in this area. The Department of Health, Northern Ireland (2011) highlights the importance of communicating with service users, carers, and the public when engaging with the public and service users. The Department advocates the pro-active involvement of service users and carers in the planning of service frameworks, and that through this improvement can be shared. Research involving service users is beneficial as identified by The Sainsbury Centre (2001), and can make a difference to their life, for example in terms of self-esteem. Therefore increasing awareness of what the forensic team do could

therefore empowers service users to provide feedback on services and share ideas for improvement.

A one way ANOVA indicated that there is a statistically significant difference between groups ($F=11.358$ $p < .001$) A post-hoc comparison of means indicated that the professional (2.03) and family groups (2.62) are more likely to agree with this statement positively than was the case for the patient group (3.11) ($p < 0.001$).

Research Question Three (CS3): Relationships between the forensic team and other teams could be improved upon

One of the key recommendations from the Northern Ireland Bamford Review (2006) was that a co-ordinated joint strategic approach should be developed between agencies and teams. They proposed that partnerships should be composed of service users and carers, commissioners, and providers of services, representatives from forensic and interconnecting mental health services, as well as from criminal justice agencies, and representatives from the wider community. Research by the Center for Substance Abuse Treatment, Rockville (2005) states that Criminal justice clients are particularly sensitive to what staff actually do, in contrast to what staff say. They state that words about personal accountability with this population will only have a modest impact unless staff are willing to model the behaviour and hold themselves to the same standards. The modelling of this behaviour – of insisting on demonstrating one's accountability instead of waiting for others to demand it – can be very powerful in helping criminal justice clients change. They highlight the importance of collaboration between treatment staff and

criminal justice staff, since both need to model personal accountability in their behaviour.

It was hypothesised that the professionals would endorse the need for improved working arrangements and the patient and family groups would be unaware of problems in this area.

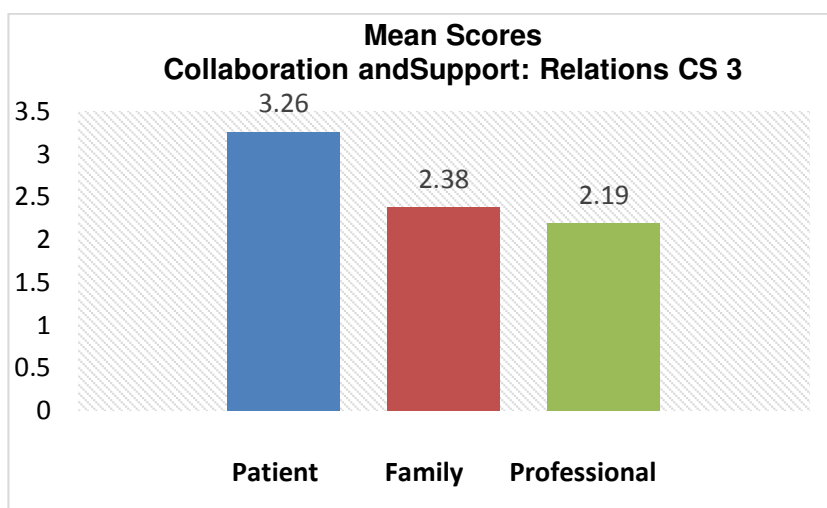
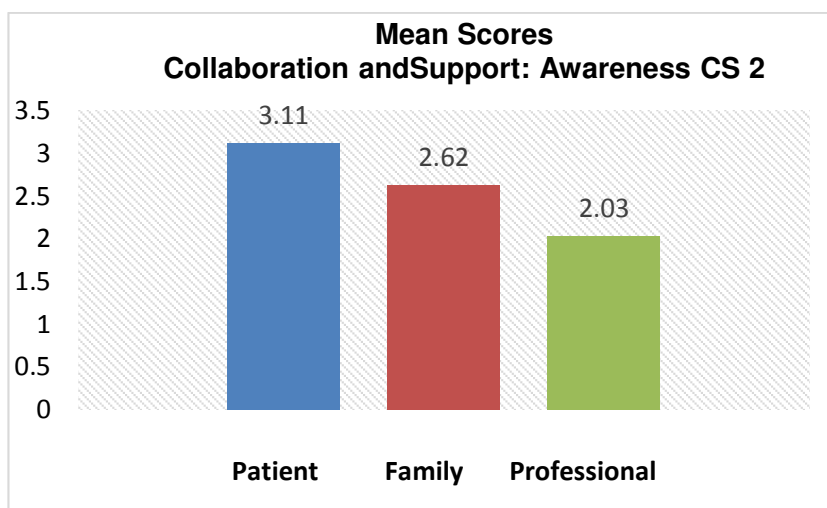
A one way ANOVA indicates that there is a statistically significant difference between groups ($F=9.268$ $p < .001$) Post-hoc comparison of means indicates that the professional group (2.19) and family group (2.38) are more likely to agree with this statement than was the case for the patient group (3.26) ($p < 0.001$).

Table 4

CS - Collaboration and Support

CS	Patient		Family		Professional		F	P
	Mean	SD	Mean	SD	Mean	SD		
CS1 Hospital and Comm Services	3.15	1.099	2.15	1.068	1.97	0.910	11.065	0.000
CS2 Awareness	3.11	1.050	2.62	1.044	2.03	0.696	11.358	0.000
CS3 Relations	3.26	1.059	2.38	1.121	2.19	0.889	9.268	0.000

Bar Charts for Means of Collaboration and Support Theme



Theme 5: Family Involvement and Support (FIS)

Full details of the results (means, standard deviations, F and p values) are presented in Table 5 below. The main findings are summarised in the following sections.

Research Question One (FIS1): The family plays a crucial role in the management of a forensic patient ('What Works' model)

Ward et al. (2004) identified support as an important external factor in motivating an offender to engage in treatment. They defined support as being derived from individuals who wish the offender well and who would like to see him or her succeed in overcoming their problems. Interestingly, they say that while family and friends may provide some support, this may not be enough, or may not be necessary for some individuals. What appears to be critical from their research is the presence of professional support that encourages the offender to enter a specific programme and continue to engage in it. Slaght (1999) reported that family relationships are an important part of an offender's life. In his study concerning offenders with substance abuse problems, the only independent variable related significantly to relapse at three months after release to the community was whether the offender was getting along with family members. Those who were getting along very well with family members were the least likely to use drugs.

It was hypothesised that all three groups would endorse this statement, particularly the family group. This was identified as important by families in

the previous study in that they requested more support in risk managing someone with forensic needs.

A one way ANOVA indicated that the groups did not differ from each other ($F=1.331$; ns).

Research Question Two (FIS2): More support should be offered to the family of patients with forensic needs

Research has identified that family can be a supportive factor for people with forensic mental health needs (Ward, 2003; Slaght, 1999). However, involving family members can also be a source of conflict, (Slaght, 1999). For example, if a person is moving from incarceration into the community they often find that existing family problems are still present or worse. Maruna (2001) identified that if someone else, often a partner, believes in the person then they can realise that they do have personal value and this can help facilitate a new path to desistence. He advocates the idea that families can help individuals see their possibilities and keep them interested in treatment. It would be prudent, then, for services to provide support to families to help them engage productively with their family member and ultimately with treatment.

It was hypothesised that all three groups would endorse the view that more support should be offered to family members; particularly the family group.

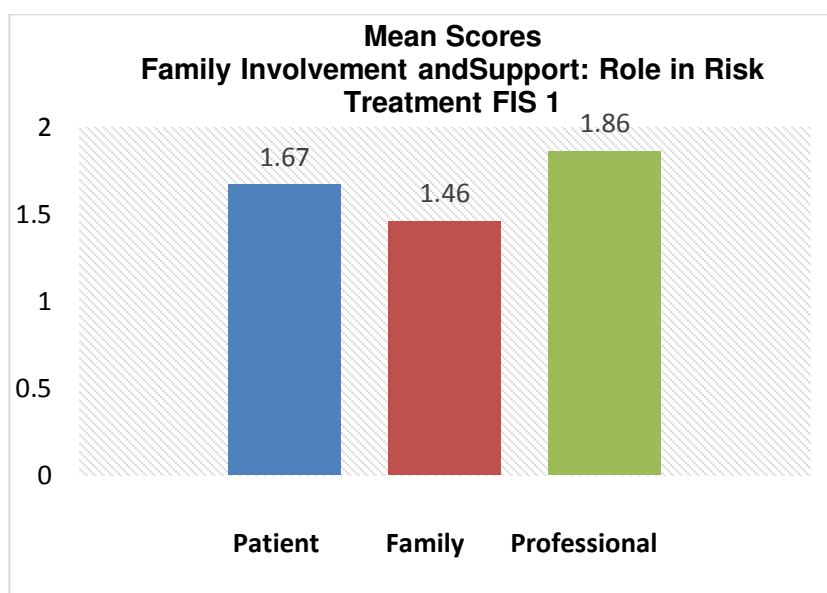
A one way ANOVA indicated that the groups did not differ from each other ($F=1.002$; ns).

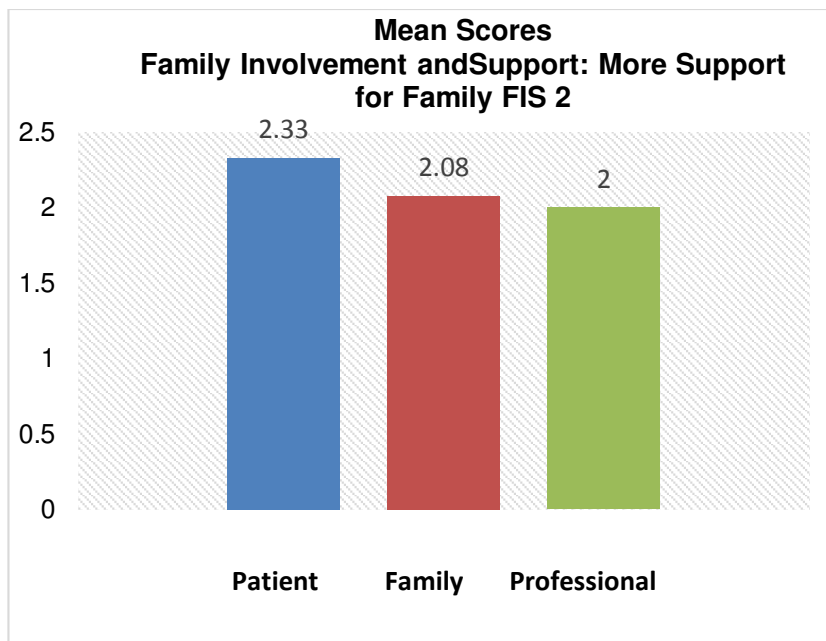
Table 5

FIS - Family Involvement and Support

FIS	Patient		Family		Professional		F	P
	Mean	SD	Mean	SD	Mean	SD		
FIS1 Role in Risk & Treatment	1.67	0.920	1.46	0.519	1.86	0.762	1.331	0.270
FIS2 More support for family	2.33	1.144	2.08	0.862	2.00	0.756	1.022	0.365

Bar Charts for Means of Family Involvement and Support Theme





Theme 6: Psychological Wellbeing (PWB)

Full details of the results (means, standard deviations, F and p values) are presented in Table 6 below. The main findings are summarised in the following sections.

Research Question One (PWB1): Social outlets and relationships help promote an offence-free life ('Good Lives', 'What Works' and 'Risk-Need-Responsivity' models)

This was identified as important in the previous study. The patient group had the most to say on the subject, particularly with regard to the need for social activities and engagement with a positive peer group. It was hypothesised that all three groups would endorse this statement but more so the patient and family groups.

This is reflective of the Good Lives model where it is stated that offender treatment must be holistic and focus on many areas of an individual's life rather

than just the offending. Ward (2007) argues that in order to truly address risk, a holistic approach must be adopted and the whole person should be treated rather than merely focusing on criminogenic needs. Wallcraft (2005) found that in addition to accessing appropriate treatments, positive relationships, financial security, satisfying work, and personal autonomy were important factors in helping the recovery of people with mental health problems.

A one way ANOVA indicated a statistically significant difference between groups ($F=5.288$; $p < .05$). Post-hoc comparison of means indicated that the patient group (patient 1.46) were more likely to agree with the statement than the other two groups (family 1.77; professional 2.11) ($p < 0.001$).

Research Question Two (PWB2): Persons with a mental illness and forensic history are fearful of their illness

This was identified as an issue in the previous study, where it was felt by families that patients often hide mental health problems from professionals. It was hypothesised that the patient and family group would endorse this statement more so than the professional group.

The Stigma Shout project led by the organisation Rethink conducted a survey in England (2008) to understand the experiences of people directly affected by mental health problems. The survey included both service users and carers. The survey confirmed that stigma and discrimination is all-pervasive with close to 9 out of 10 service users (87%) reporting its negative impact on their lives. Two thirds stopped doing things because of stigma and two thirds stopped doing things because of the fear of stigma and discrimination.

Research undertaken by the Health Promotion Agency, Northern Ireland (2006) examining public attitudes, perceptions, and understanding of mental health in Northern Ireland amongst the general public, identified that although there was a common recognition that anyone can suffer from mental health problems, and that such persons should have the same rights as everyone else, fewer participants reported a willingness to talk to a person with mental health problems (68%) and over half the sample (55%) admitted they would not want to disclose their own mental health problem. This confirms stigma and fear around the issue of mental health and illness.

A one way ANOVA indicated a statistically significant difference between groups ($F = 8.319$; $p < .001$). Post-hoc comparison of means indicated that the family group (family1.46) were more likely to agree with the view that persons with a mental illness and forensic history are fearful of their illness than the other two groups (patient 2.19; professional 2.64, $p < 0.001$).

Research Question Three (PWB3): Families of people with a mental illness and forensic history are fearful of the impact on the family

It was hypothesised that the patient and family group would be more likely to endorse this statement than the professional group. The Stigma Shout project of 2008 reported lower levels of personal stigma and discrimination for carers. However 85% of carers did say that stigma and discrimination was a problem for the person they supported. The research undertaken by Stigma Shout also reported that carers and service users report similar areas of their life that are damaged, including: employment, building new friendships and retaining existing ones, being able to join groups and take part in activities, feeling the

confidence to go out and about, the ability to openly disclose mental health problems for fear of being judged, and the ability to challenge professionals. Family carers highlighted the difficulty of going on holiday because of the reactions of holidaymakers to the person they cared for.

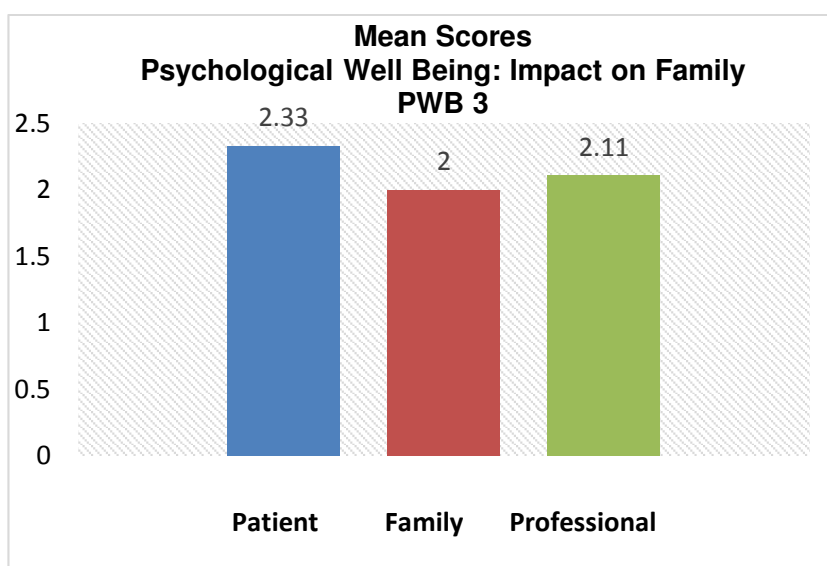
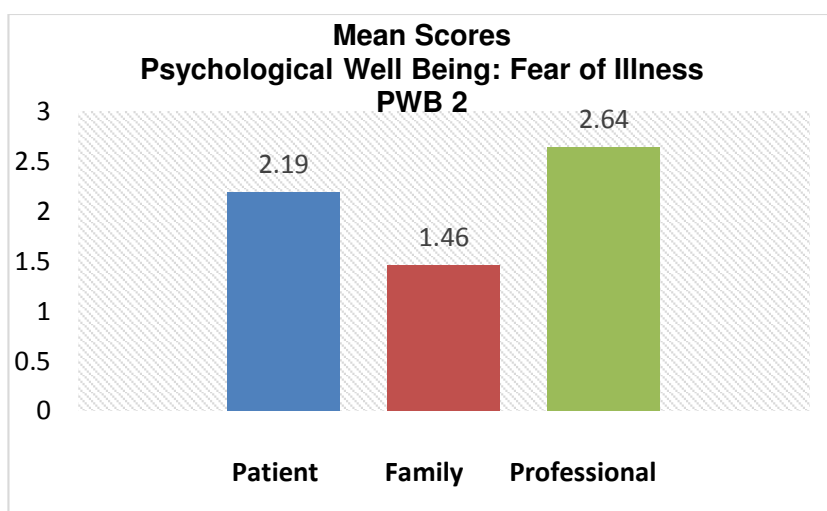
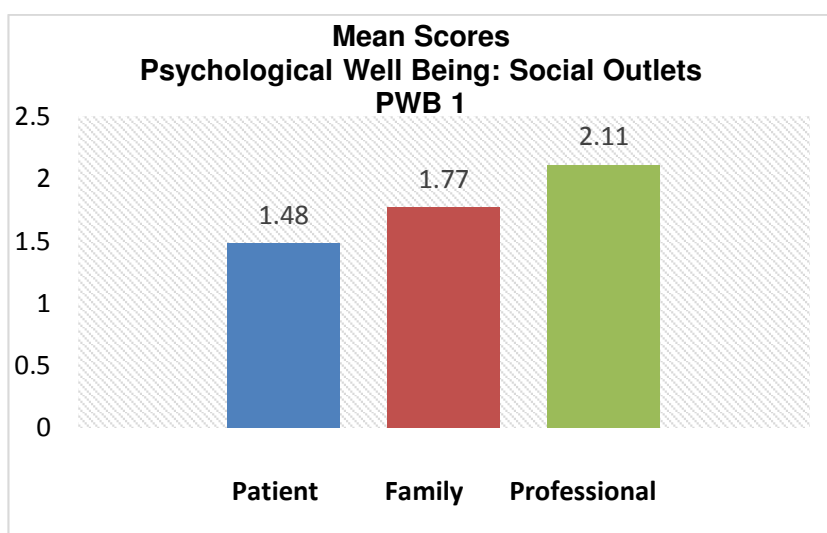
A one way ANOVA indicated that the groups did not differ from each other ($F = 0.623$; ns).

Table 6

PWB - Psychological Well Being

PWB	Patient		Family		Professional		F	P
	Mean	SD	Mean	SD	Mean	SD		
PWB1 Social Outlets	1.46	0.509	1.77	0.927	2.11	0.854	5.288	0.007
PWB2 Fear of Illness	2.19	1.075	1.46	0.660	2.64	0.833	8.319	0.001
PWB3 Impact on Family	2.33	1.209	2.00	1.225	2.11	0.667	0.623	0.539

Bar Charts for Means of Psychological Wellbeing Theme



Theme 7: Public Perception and Awareness

Full details of the results (means, standard deviations, F and p values) are presented in Table 7 below. The main findings are summarised in the following sections.

Research Question One (PPA1): People who have a mental illness and forensic history are perceived differently by others

It was hypothesised that the family and patient groups would be more likely to agree with this statement. The Stigma Shout project (2008) examined the perceptions of both family and patients concerning mental health problems and the perceived support they got from their friends, community, family, and professionals with regard to their mental health problems. In a workshop with people with mental health problems, participants identified family as having lower expectations of them because of their mental health, friends not wanting to know them when their mental health issue was disclosed, and neighbours labelling them because they were afraid of the person. However in this research, positive experiences were highlighted by Community Psychiatric Nurses and psychologists.

A one way ANOVA indicated that the groups did not differ from each other ($F = 2.541$; ns).

Research Question Two (PPA2): Public perception and awareness of mental illness and offending behaviour has a negative impact on treatment and recovery

It was hypothesised that the family and patient groups would be more likely to agree with this statement. Ward and Brown (2004) state that in rehabilitating offenders, acceptance and forgiveness from others is influential in relation to a person's ability to feel valued and to desist from offending. The Stigma Shout project (2008) reported that stigma and discrimination stopped people from engaging in everyday activities – for example, going shopping, taking a holiday, making new friends – as well as preventing effective engagement with mental health professionals. This research therefore suggests that the perception of the public, with regard to mental illness in particular, can negatively impact not only on a person's ability to engage in everyday activities, but also upon their motivation to participate in treatment; this influences recovery and rehabilitation.

A one way ANOVA indicated that the groups did not differ from each other ($F= 1.734$; ns).

Research Question Three (PPA3): The public need to be educated more on mental illness and offending behaviour

It was hypothesised that the family and patient groups would be more likely to agree with this statement. Research by the Health Promotion Agency, Northern Ireland (2006) indicated that the public requires more education about mental illness. Their findings also interestingly suggest that not only do the public require more education, but that health professionals such as GPs as well as significant others (e.g. those closely connected to people who are experiencing mental illness including mothers and partners) also need education. The findings of this research are reflective of issues

identified through the focus groups in study one, where families were seeking more support and education in order to manage their family members' mental illness and offending behaviour.

A one way ANOVA indicated that the groups did not differ from each other ($F = 0.335$; ns).

Research Question Four (PPA4): The religious or cultural divide in Northern Ireland has had a negative impact on the recovery and rehabilitation of people with a mental illness

It was hypothesised that the religious divide in Northern Ireland is likely to have a negative impact on rehabilitation and recovery for people with a mental illness and offending behaviour. In his 2004 critique of the medicalization of war trauma, Summerfield argues that PTSD checklists potentially turn functioning, coping, and resilient individuals into medical 'cases'. He examined over 800 asylum-seekers and refugees while working for the Medical Foundation, and concluded that the vast majority were upset but not ill (Summerfield, 2004). He argues that a focus on individual models of treatment based on early intervention and re-visiting traumatic events may do more harm than good. Looking at similar issues in Northern Ireland, Gilligan (2006) identifies and critiques core assumptions about peace, trauma, and conflict. He concludes: 'Therapists cannot adequately answer the question 'what was it all for?' because it requires a political or moral answer ... The introspective, individualised and depoliticised approach to dealing with political violence is inherently self-limiting and may even serve

to undermine peace-building efforts by promoting a view of the human subject as inherently vulnerable and in need of professional support'. (2006: p 339).

A one way ANOVA indicated a statistically significant difference between groups ($F= 3.626$; $p < .05$). Post-hoc comparison of means indicated that the professional group (2.33) were more likely to agree with this statement than the other two groups (patient 2.93; family 2.92) ($p < 0.05$).

Research Question Five (PPA5): There is still stigma attached to mental illness and offending behaviour

It was hypothesised that the family and patient groups would be more likely to agree with this statement. Overall the research suggests that there is still stigma attached to mental illness and offending behaviour. This is clear from local research based in Northern Ireland (Northern Ireland Public Health Agency, 2008).

A one way ANOVA indicated that the groups did not differ from each other ($F= 1.860$; ns).

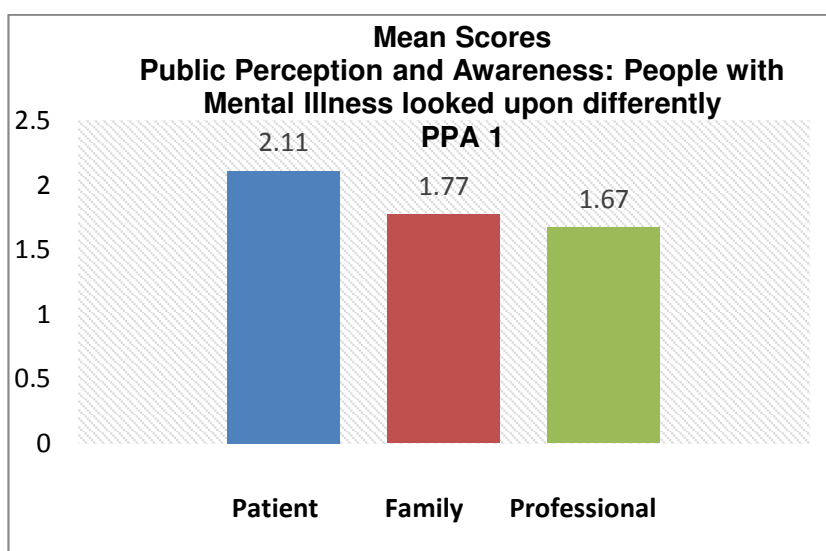
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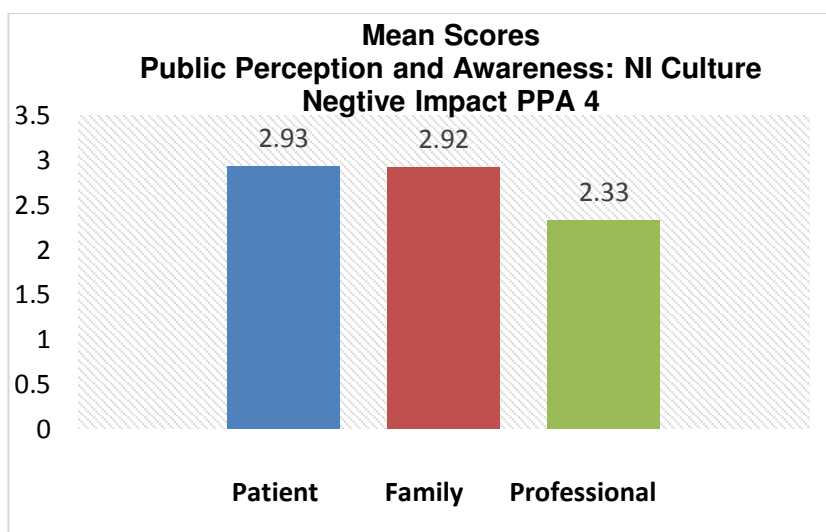
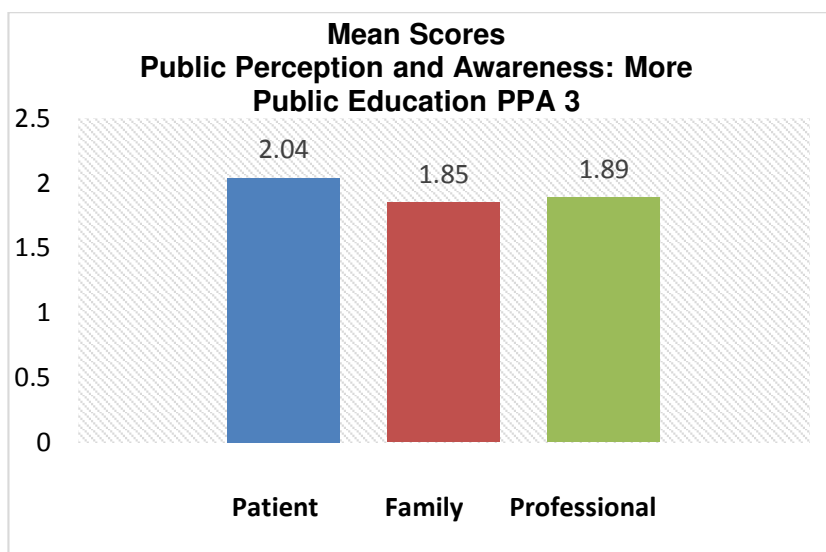
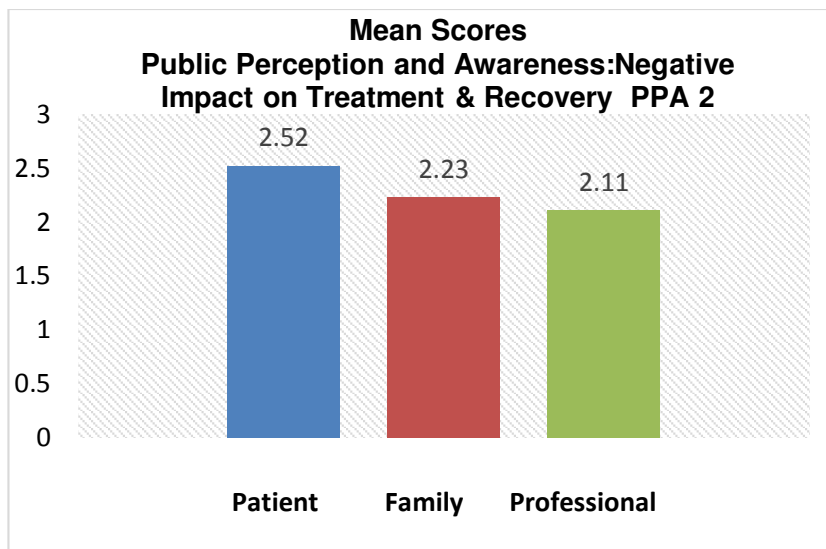
PPA - Public Perception and Awareness

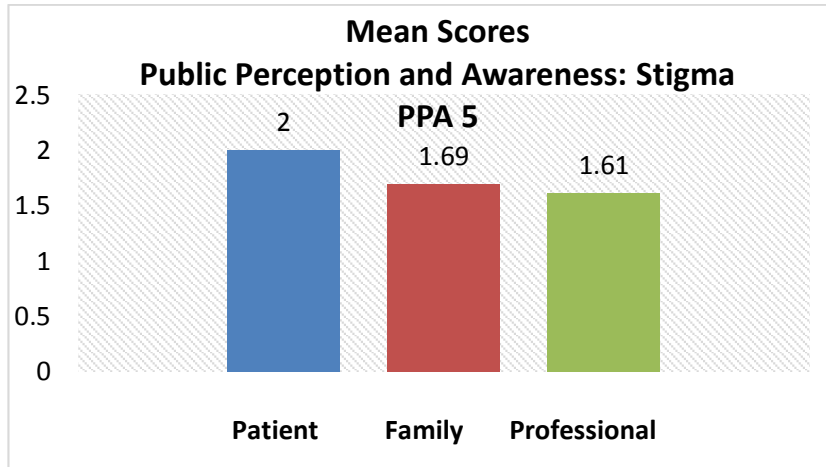
PPA	Patient		Family		Professional		F	P
	Mean	SD	Mean	SD	Mean	SD		

PPA1 People with mental illness looked upon differently	2.11	1.013	1.77	0.599	1.67	0.632	2.541	0.086
PPA2 Negative impact on treatm't and recovery	2.52	1.051	2.23	1.013	2.11	0.622	1.734	0.184
PPA3 More Public Educ.	2.04	0.854	1.85	0.899	1.89	0.785	0.335	0.717
PPA4 NI culture negative Impact	2.93	1.035	2.92	1.256	2.33	0.756	3.626	0.032
PPA5 Stigma	2.00	1.000	1.69	0.630	1.61	0.688	1.860	0.163

Bar Charts for Means of Public Perception and Awareness Theme







Theme 8: Living Environment (LE)

Full details of the results (means, standard deviations, F and p values) are presented in Table 8 below. The main findings are summarised in the following sections.

Research Question One (LE1): People with forensic mental health needs require a living environment that is specific to their needs ('What Works' and 'Risk-Need-Responsivity' models)

In the previous study a patient's living environment was identified as an important factor in their rehabilitation. It was hypothesised that all three groups would agree with this statement. This is currently a very relevant issue in community forensic services, particularly the lack of suitable accommodation for this client group. Ward and Brown (2004) highlight the importance of rehabilitating offenders using a holistic approach that meets not only their criminogenic needs but also their non-criminogenic needs.

Living in an environment specific to their needs and reflective of the Good Lives model in meeting the primary human good of a safe place to live is an important factor in recovery and rehabilitation.

A one way ANOVA indicated that the groups did not differ from each other ($F = 0.045$; ns).

Research Question Two (LE2): People with forensic mental health needs require additional support in their living environment

It was hypothesised that all three groups would endorse this statement. Melzer, Tom, Brugha, Fryers, Grounds, Johnson, Meltzer, and Singleton (2002). who conducted research into the resettlement of offenders from prison into the community, found that 96% of offenders with mental health needs were released into the community without supported housing. This research argues that, for offenders with mental health needs, continuity of care and the opportunity to engage with mental health services are vital. Dunn (1999) highlighted that effective resettlement to the right living environment can have a positive impact on reducing offending and increasing social inclusion.

A one way ANOVA indicated that the groups did not differ from each other ($F = 2.163$; ns).

Research Question Three (LE3): In Northern Ireland there is a negative bias towards locating people with forensic mental health needs in supported living environments

It was hypothesised that all three groups, but particularly the patient and family groups, would agree with this. Environment appears to be of importance in reducing risk factors and reaching the goal of a good life. (Incardi, Martin, and Surrat, 2001; Taylor, 2002; McGuire, 2010). However, in Northern Ireland a person's religion may be a motivating factor in choosing the community they want to resettle to, which may not always be responsive to the person's needs. With this there is a risk that people may get trapped in a cycle of poor mental health and re-offending.

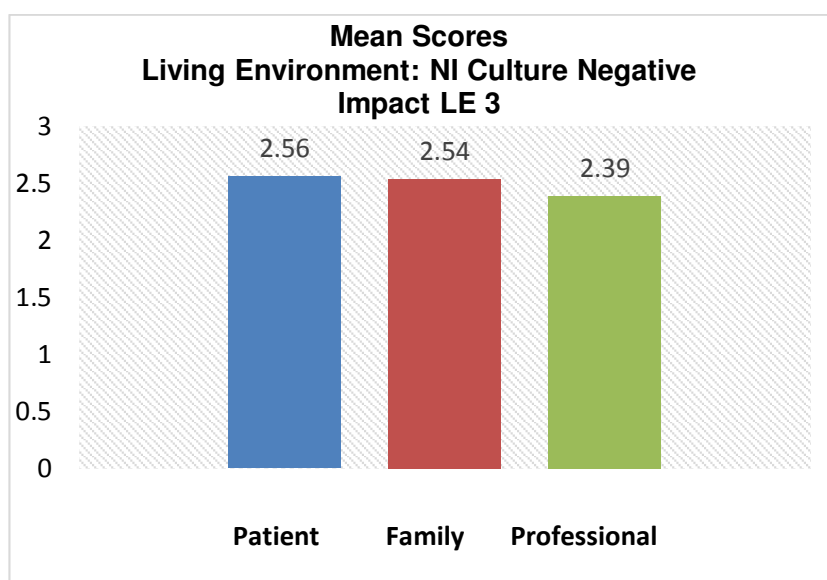
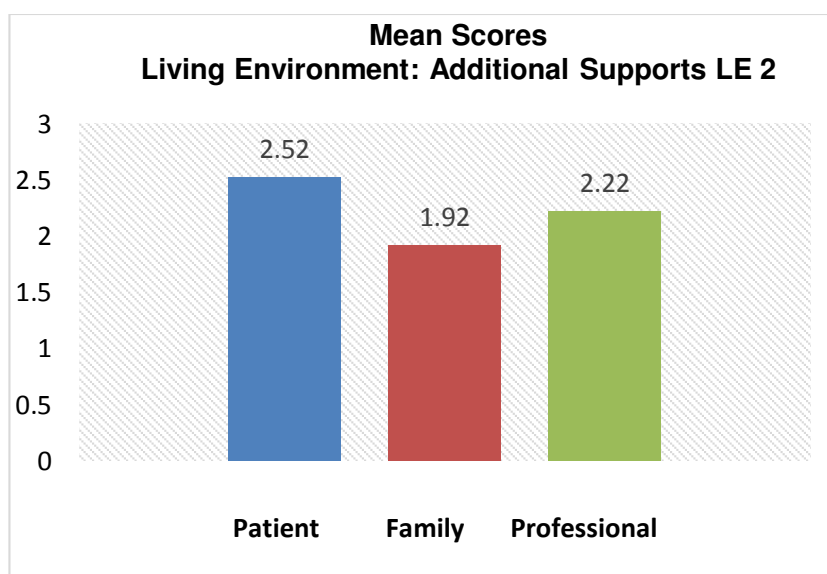
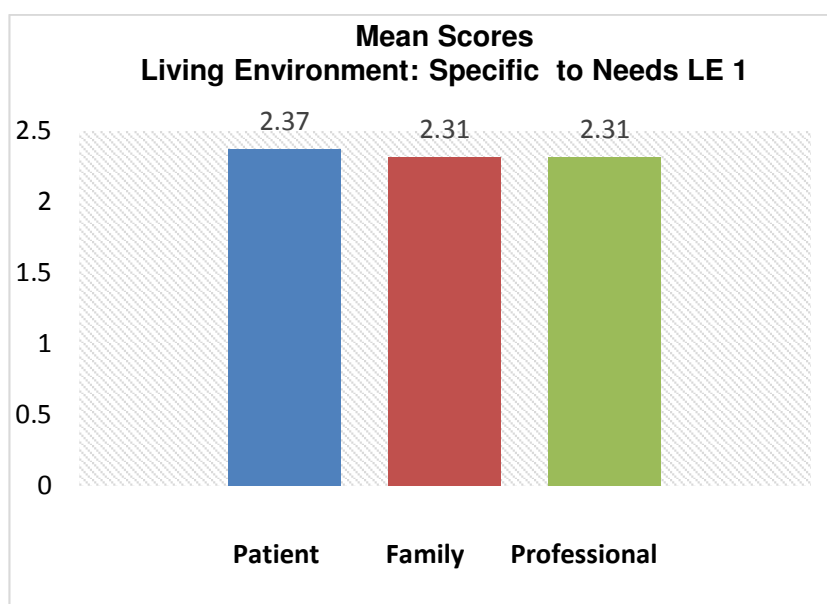
A one way ANOVA indicated that the groups did not differ from each other ($F = 0.320$; ns).

Table 8

LE - Living Environment

LE	Patient		Family		Professional		F	P
	Mean	SD	Mean	SD	Mean	SD		
LE1 Specific to Needs	2.37	1.079	2.31	0.751	2.31	0.786	0.045	0.956
LE2 Additional Supports	2.52	1.051	1.92	0.277	2.22	0.866	2.163	0.122
LE3 NI Culture Negative Impact	2.56	0.847	2.54	0.877	2.39	0.903	0.320	0.727

Bar Charts for Means of living Environment Theme



Theme 9: Professional Characteristics (PC)

Full details of the results (means, standard deviations, F and p values) are presented in Table 9 below. The main findings are summarised in the following sections.

Research Question One (PC1): Gender influences the working relationship between patient and professional

It was hypothesised that all three groups would be unlikely to endorse this statement. Much of the research literature concerning working relationships between professionals and offenders, emphasises the importance and value of the therapeutic relationship, (Ward and Brown, 2004; Marshall et al., 2003). However, less is said about whether specific characteristics such as a person's gender, religion, or culture influence the relationship. Wintersteen, Mensinger, and Diamond (2006) examined whether gender and racial differences impacted on the therapeutic alliance between adolescent substance abusers and their therapists. Six hundred adolescent substance abusers and their therapists, from a large randomized clinical trial, were grouped according to matches and mismatches on both gender and race, and alliance ratings were collected from both patients and therapists. Results revealed that those matched by gender reported higher alliances and were more likely to complete treatment. Results suggest that, although multicultural training remains critical, training emphasis should also be placed on understanding how gender and racial differences affect therapeutic processes.

A Finnish study by Artkoski and Kuusisto (2013) which explored the relationship between the female therapist and the client's gender reported that female clients were more likely to want a female therapist, whereas men did not express such preferences. The research highlighted that a combination of a female therapist and a female client predicted a better therapeutic alliance during treatment, but there were no differences between male and female clients in long-term outcomes. The findings suggested that clients received treatment of the same quality regardless of their gender.

A one way ANOVA indicates a statistically significant difference between groups ($F = 16.603$; $p < .001$). Post-hoc comparison of means indicated that the professional group (2.67) were more likely to agree with the statement (that gender influences the working relationship between patient and professional) than the patient and family (patient 3.74; family 4.00) ($p < 0.001$).

Research Question Two (PC2): Cultural background influences the working relationship between patient and professional

It was hypothesised that all three groups would be likely to disagree with this statement. Asnaani and Hofmann (2012) explored how to establish a strong therapeutic alliance across cultural lines. Through an individual case study of they established a number of guidelines for effective collaboration in multi-cultural therapy. These are relevant to the current study and include: conducting a culturally-informed but person-specific functional assessment of the problem, self-education on the part of the therapist about cultural norms, training for therapists in working with people from different cultures,

respecting another person's culture, incorporating a client's culturally-related strengths and resources into treatment, and identifying technique-specific cultural modification.

A one way ANOVA indicates a statistically significant difference between groups ($F = 42.659$; $p < .001$). Post-hoc comparison of means indicated that the patient group (1.59) and family group (1.38) were more likely to agree with the statement (that cultural background influences the working relationship between patient and professional) than the professional group (3.00) ($p < 0.001$).

Research Question Three (PC3): Religion influences the working relationship between the patient and professional

Research has illustrated that the effectiveness of psychotherapy can be improved by tailoring psychotherapy to one or more of six patient characteristics: reactance level, stage of change, preferences, culture, coping style, and religion/spirituality. Two more dimensions, patient expectations (Constantino, Glass, Arnkoff, Ametrano, and Smith, 2011) and patient attachment style (Levy, Ellison, Scott, and Bernecker, 2011) are also related to treatment outcome.

Pies and Geppert (2013) suggest that transference/countertransference issues can arise when there is a mismatch between the religious convictions of therapist and patient. They state, for example, that the secularly oriented therapist may unconsciously fantasize that he or she will 'liberate' the devoutly religious patient from the fetters of religious dogma. They also argue that

some secular therapists may unconsciously (or consciously) feel that devoutly religious patients are weak-minded, deluded, dependent, or incapable of independent thought. Conversely, a religiously-oriented therapist may unconsciously entertain the wish to convert or 'save' a nonreligious patient, viewing the therapy in terms of redemption rather than the restoration of mental health.

In this study mean scores are not relevant as this statement was only applied to one group (Professional).

Research Question Four (PC4): Personal qualities such as empathy, rapport and trust are as important as technical skills when working with someone with forensic mental health needs ('Risk-Need-Responsivity' model)

Much has been said in the research literature about the importance of the therapeutic alliance between therapist and offender. Elliott, Bohart, Watson, and Greenberg (2011) found that empathy predicted treatment outcome consistently across different theoretical orientations (for example, CBT, humanistic), treatment formats (individual, group), and levels of client problem severity. It was strongest for client- and observer-rated empathy. Empathy also appeared to predict outcome better for less experienced therapists.

Bordin, (1994) suggested the alliance in the early stages of treatment is built principally on a positive *emotional bond* between therapist and client (such as trust, respect, and liking), their ability to *agree on the goals* of the treatment,

and their establishment of a mutual *consensus about the tasks* (for example, homework, Socratic dialogue, free association) that form the substance of the specific therapy. Horvath, Del Re, Flückiger, and Symonds, (2011) conducted a meta-analysis of the research to examine the relationship between the alliance in individual therapy and treatment outcome. The review covered the period between 1973 and 2009 (inclusive). They found that alliance, along with therapist effects, is one of the strongest validated factors influencing therapy success.

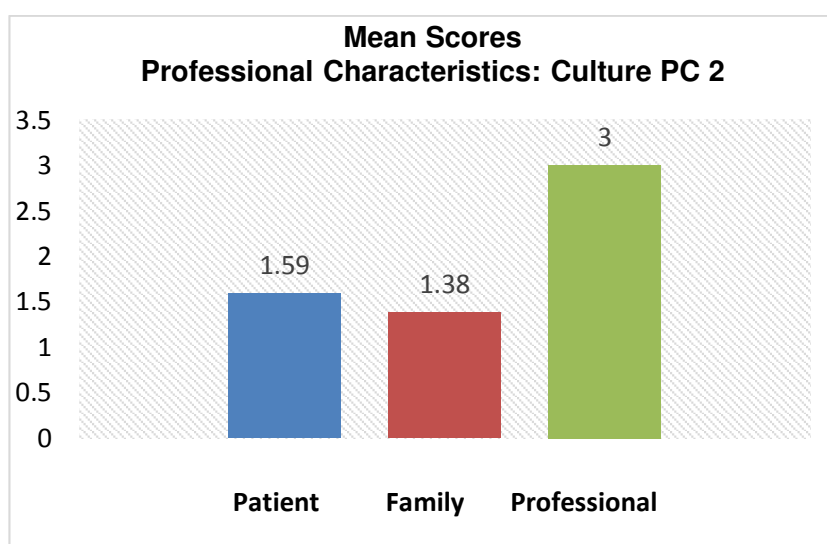
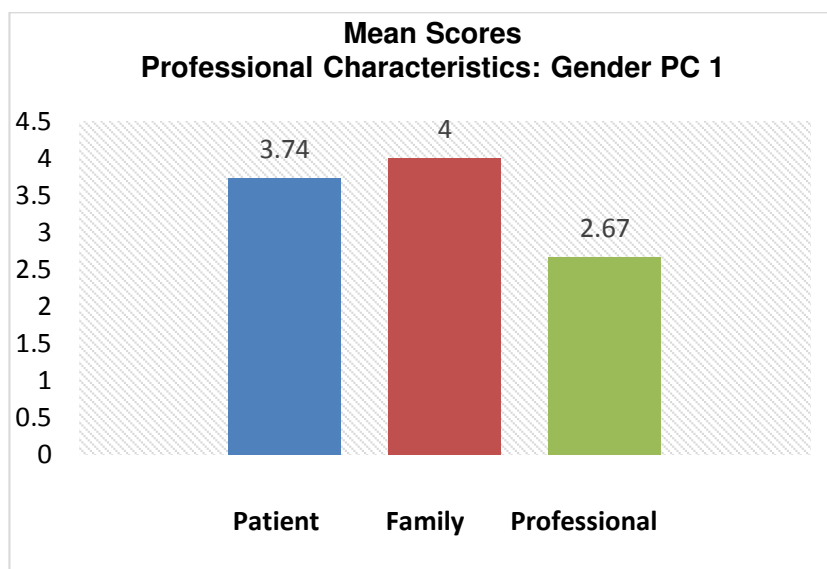
Only the professional group completed this item. Therefore, as there were fewer than two groups for the dependent variables, PC 3 and PC 4, no statistics are computed.

Table 9

PC - Professional Characteristics

PC	Patient		Family		Professional		F	P
	Mean	SD	Mean	SD	Mean	SD		
PC1 Gender	3.74	0.944	4.00	0.577	2.67	0.926	16.603	0.00
PC2 Cultural	1.59	0.694	1.38	0.506	3.00	0.756	42.659	0.00
PC3 Religion	N/A	N/A	N/A	N/A				
PC4 Personal Qualities	N/A	N/A	N/A	N/A				

Bar Charts for Means of Professional Characteristics Theme



Theme 10: Governance (GV)

Full details of the results (means, standard deviations, F and p values) are presented in Table 10 below. The main findings are summarised in the following sections.

Research Question One (GV1): Organisational constraints (resources, policies) impede on the rehabilitation of offenders ('What Works' model)

The previous study highlighted the perceived constraints that an organisation can unintentionally place on treatment and rehabilitation. It was hypothesised that professionals strongly agree with this statement. However, it is likely that patients and family groups may not be fully aware of the impact of resources on services. The principles of the 'Risk-Need-Responsivity' model (Andrews and Bonta 1998) indicate that for rehabilitation to be effective the organisation needs to value the difference that treatment can make in an offender and their family's life. The principles of the 'Risk-Need-Responsivity' model also advocate that managers need to select and train staff well to ensure programme integrity. Organisational constraints, whether financial or resource-based, can impact the quality of treatment delivered, thus compromising treatment success and robust risk management.

A one way ANOVA indicated a statistically significant difference between groups ($F = 4.696$; $p > 0.05$). Post hoc comparison of means indicated that the professional group (2.03) were more likely to agree with the statement that organisational constraints (resources, policies) impede on the rehabilitation of offenders than the patient group (2.67) and family group (2.69).

Research Question Two (GV2): Improvements need to be made to forensic services to ensure a whole systems approach so that a 'silo mentality' when working with patients is avoided

It was hypothesised that professionals would be more likely to agree with this statement. It is likely that patients and family groups may not be fully aware of the impact of a silo approach to services. A study by Sutcliffe, Lewton, and Rosenthal, (2004) reveals that social, relational, and organizational structures contribute to communication failures that have been implicated as major contributors to adverse clinical events and outcomes. Another study by Flin, Fletcher, McGeorge, Sutherland, and Patey, (2003) shows that the priorities of patient care differed between members of the health care team and that verbal communication between team members was inconsistent.

The Bamford Review Northern Ireland (2006) stressed the importance of collaborative working between teams when working with forensic patients, and that this particularly should be the case when managing forensic patients in the community.

A one way ANOVA indicated a statistically significant difference between groups ($F = 7.998$; $p < 0.001$). Post-hoc comparison of means indicated that the professional group (2.08) and family group (2.62) in comparison with the patient group (3.07) ($p < 0.001$) were more likely to agree with the statement (that improvements need to be made to forensic services to ensure a whole

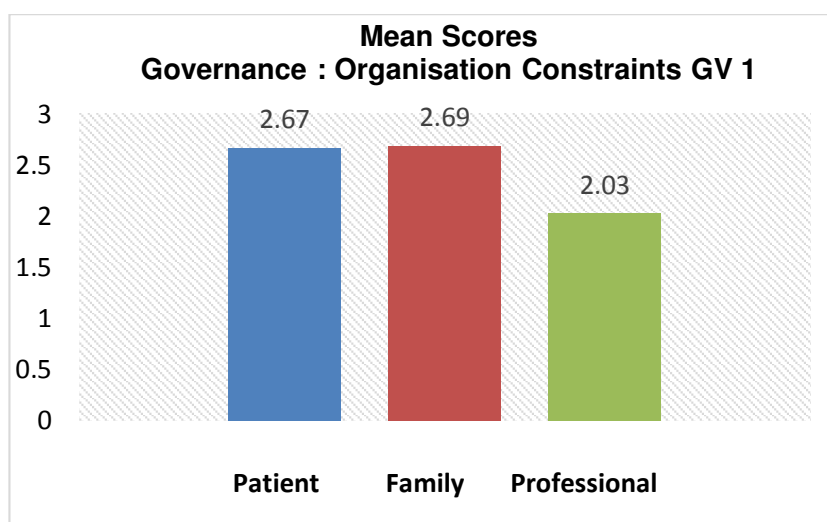
systems approach, so that a 'silo mentality' when working with patients is avoided).

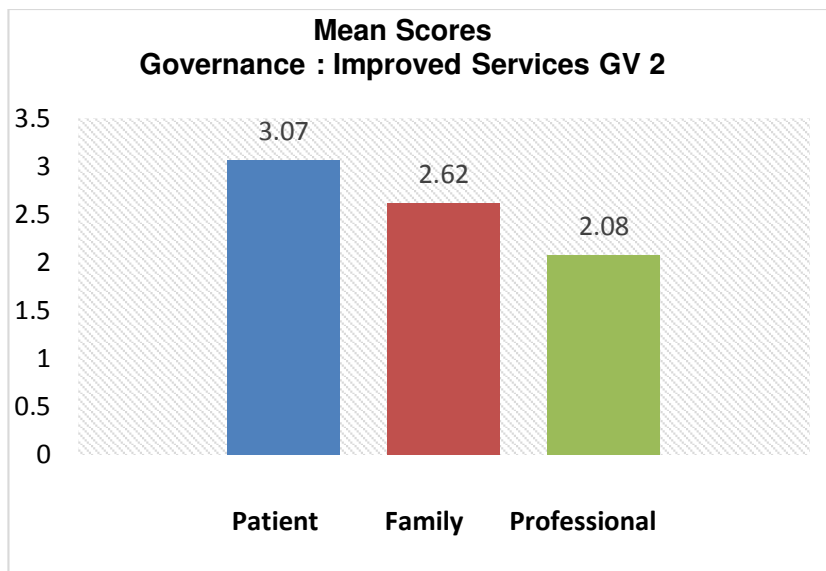
Table 10

GV – Governance

GV	Patient		Family		Professional		F	P
	Mean	SD	Mean	SD	Mean	SD		
GV1 Organisation Constraints	2.67	1.038	2.69	1.182	2.03	0.696	4.69 6	0.01 2
GV2 Improved Services	3.07	1.035	2.62	1.044	2.08	0.906	7.99 8	0.00 1

Bar Charts for Means of Governance Theme





5.6 Discussion of Study Two: Questionnaire Findings

Introduction

The overall aim of study two was to compare the perspectives of patients, families, and professionals, in terms of forensic mental health treatment for patients in the community. Using a questionnaire approach, the ten themes that emerged from the focus groups in study one were explored in more detail. It was hypothesised that there would not be significant differences between the three groups' perspectives in terms of treatment for forensic mental health patients. Within each theme separate hypotheses were established.

The aims and hypotheses under each theme will be summarised and discussed.

Risk Management

Research Question 1: The role of the key worker is important in a patient's risk management. It was hypothesised that all three groups would agree with this statement.

Research Questions 2, 3, 4: Gender, religion or age of the key worker does not have an impact on risk management. It was hypothesised that these would not be significant factors in risk management and treatment.

The role of the key worker in a patient's risk management was identified as important by all three groups. This is an endorsement of the results obtained in study one. In that study, all three groups emphasised the importance of the key worker in relation to a patient's risk management plan. For patients and professionals this was about identifying 'warning signs' or 'triggers' for deterioration in mental health and risk of offending behaviour. For families, securing the best match between risk management and treatment of the person was viewed as important. The results of the present study indicate that the family group emphasise the key worker role slightly more than the patient and professional groups. This perhaps highlights the supportive role they see the key worker providing, which is a theme in its own right, 'Family Involvement and Support', identified from the previous study.

The gender, religion, and age of the key worker are not of great significance to the three groups, and appear to have little bearing on a patient's risk management. This is interesting, as locally within the Southern Trust, the majority of key workers are female. Some research studies have reported that women attending female therapists commit better than women attending male

therapists (Claus et al., 2007). The significance of gender has also been discussed in Finnish Social Work practice; Kuusisto and Artkoski (2013) raised an issue with regard to practices of male clients having female social workers and that male clients may be alienated by the characteristics typical of women. It was proposed that females do not necessarily have the skills to identify a male client's needs, and that men therefore are not met with sufficient understanding. It has also been suggested that female workers in particular find it difficult to work with aggressive male clients (Cayouette, 1999). Further exploration of this issue in study three would be helpful.

Although the religion of the key worker was not seen as important by all three groups, it is interesting that the phrase 'Northern Ireland culture of equality' was viewed as something that may influence a patient's risk management plan. This specific view was endorsed more by the professional group. The topic of religion in Northern Ireland can be an uncomfortable one for people to discuss. In that sense, perhaps directly asking whether the religion of a key worker is important was difficult or uncomfortable for participants to answer.

Research Question 5: A risk assessment and treatment plan is important. It was hypothesised that all three groups would agree with this statement.

Both the previous and present study highlight the importance of a risk assessment and treatment plan for all three groups, which is reflective of the 'What Works' and 'Risk-Need-Responsivity' models. The 'risk' and 'need' principles in the 'Risk-Need-Responsivity' model (Andrews, Bonta, and Hoge, 1990) emphasise the importance of matching the level of service to the

offender's risk to re-offend, and assessing criminogenic needs and targeting them in treatment. The professional group endorsed the idea of these principles more in the present study than the patient and family groups. This is probably because they are the group who formulate a risk assessment and treatment plan and are more aware of its significance. In the previous study more comment was made by the patient and family groups about the importance of attending to individual needs when undertaking risk assessments. Interestingly, this is more reflective of the 'responsivity' principle in the 'Risk-Need-Responsivity' model (1995), which suggests that the offender's ability to learn from rehabilitative intervention should be maximised through providing cognitive behavioural treatments and interventions that are tailored to the learning style, motivation, abilities, and strengths of the offender.

A question for further exploration is whether attention to detail by professionals when undertaking risk assessments unnecessarily dilutes the therapeutic relationship. Nevertheless, it is clear from both studies that the key worker is important in both risk management and treatment to families and patients. Further exploration of this issue would be helpful.

Research Question 6: Being risk-averse has a negative impact on risk management and treatment. It was hypothesised that professionals would be more likely to endorse this statement.

Ward's 'Good Lives' model (2002) states that when assessing risk it is important to not become too overly focused on risk but also assess an individual's strengths, primary goods, and motivations. New risk assessment instruments integrate systematic intervention and monitoring with the

assessment of a broader range of offender risk factors and other personal factors that are important to treatment, (Andrews, Bonta, and Wormith, 2006). Such research would now suggest that it is important to take positive risk management steps; this is a much more motivational approach to working with offenders. McCulloch and McNeill's (2008) work on desistance-focused approaches highlights the importance of this. The results of study two appear to be in support of this ethos. Overall, there was a significant negative effect regarding the impact of being risk-averse on risk management and treatment. The family group were more likely to disagree with this statement than the professional group.

Research Question 7: The NI culture and high awareness of equality influences a patient's risk management plan. It was hypothesised that all three groups would agree with this statement.

The Northern Ireland Culture and high awareness of equality was viewed as something that may influence a patient's risk management plan. The results show that this was endorsed more by the professional group. The Programme for Government 2001-2002 identified 'Working for a Healthier People' as one of its five priorities with a focus on, among other issues, reducing health inequalities. In its Priorities for Action guidelines, the DHSSPS recognised the need to promote equality of opportunity and also its obligation to promote good relations between people of different religious beliefs, political opinion, and racial groups.

The Scottish NHS advocate that it is vital that equality and diversity is understood so that person-centred, safe, and effective care can be delivered.

They go on to say that *equality* is about creating a fairer society, where everyone can participate and have the opportunity to fulfil their potential, and no-one is unfairly disadvantaged. *Diversity* is about valuing people's differences and addressing their different needs and situations. The Scottish NHS has produced guidance for practitioners on delivering a service that tackles the barriers that might prevent some groups of people from accessing services. Their goal is to ensure that everyone is treated with dignity and respect; they support involvement, self-management, and improved outcomes for all. This ensures that equality and diversity are not 'add-ons', but should be an essential part of how we deliver our services and work together. The Northern Ireland Equality Commission also advocates the importance of health and social care, and has produced guidance to assist staff in anticipating and overcoming the kind of barriers mentioned above. For example, it should help them to understand what 'culturally competent services' means and also outlines realistic and practical strategies for responding to the needs of local black, minority ethnic, and traveller communities.

Summary

The results of study two reflect the findings of study one. The role of the key worker is viewed by all three groups as critical in the risk management of a person with forensic mental health needs. However, the family group emphasise the role of the key worker more than the professionals and patients. This suggests that family members see the key worker as a critical person for risk management and overall support. Although in this study the gender, age, and religion of a key worker do not appear to be important, these

demographics do appear to be important in other research studies, (Kuronen 2004, Cayouette 1999). This may be due to the small sample size in this study in comparison to larger-scale research. It may also be due to Northern Ireland people feeling uncomfortable when discussing religion, and thus not being forthcoming with their views. Perhaps, then, the results of this study are not reflective of true feelings. Overall, risk management is seen as a critical component for a patient's mental health and for risk reduction. This is particularly reflective of the 'Risk-Need-Responsivity' model, (Andrews and Bonta, 1994).

Treatment Intervention

Research Question 1: Patient participation in forensic therapeutic groups is important for an individual's mental health, social wellbeing and risk of offending. It was hypothesised that all three groups would endorse this statement.

The results of the present study were consistent with the previous study in emphasising the critical value of therapeutic groups. Therapeutic groups delivered to forensic patients in the Southern Trust are based on the 'Good Lives' model and address multiple criminogenic needs. The evidence suggests that offenders often experience multiple problems; it has therefore been argued that multi-modal, holistic interventions that address a range of problems are more likely to be effective in reducing reoffending (Ministry of Justice, 2010). Furthermore, there is good evidence from research conducted in the United States that cognitive-behavioural programmes for offenders can result in modest reductions in reoffending among programme participants

(Harper and Chitty, 2005). A meta-analysis of 291 program evaluations undertaken in a variety of English-speaking countries in the past 40 years was conducted by the Washington State Institute for Social Policy in 2006. They found that not all programs and services aimed at reducing re-offending are effective. Community based 'treatment' programs produced the greatest reductions in re-offending, while programmes without a treatment component such as victim-offender mediation, boot camp, intensive supervision, and electronic monitoring had no effect on re-offending. On the whole, programmes that addressed the irrational thoughts and beliefs that contributed to anti-social behaviour were effective. Studies in the UK are more mixed; however, this may be because of differences in how programmes are delivered and implemented. Process evaluations of cognitive behavioural interventions in England and Wales have reported a range of problems such as high attrition rates and long waiting lists, (Harper and Chitty, 2005). This is not the case in the current study due to smaller numbers of patients requiring, and participating in, therapeutic groups.

Research Question 2: Having a purposeful and fulfilled life plays an important role in preventing a person from re-offending. It was hypothesised that all three groups would endorse this view.

In the current study, the need in treatment for purpose and fulfilment in life with an equal focus on offending, mental health, and positive social engagement was also endorsed as important. Although the patient group endorsed the view more than the family group who endorsed it more than the professional group, the group differences were not significant. In general though, this reflects the spirit of the 'Good Lives' model. The research literature shows that

treatment strategies with the most favourable results in relation to re-offending rates are those that are 'holistic'; that is, focused on the whole range of an individual's needs, and integrated with support in the prison and community (Tombs, 1994).

Research Question 3: The troubles in Northern Ireland have had a negative impact on patient rehabilitation. It was hypothesised that the troubles may have impeded on a person's ability to benefit from treatment.

The impact of the 'troubles' in Northern Ireland was an unknown quantity in this research. Although all three groups were more likely to endorse the statement than not, with the professional group endorsing it more than the family group, who endorsed it more than the patient group, the group differences were not significant. It could be hypothesised that this occurred because of the number of professionals with a criminal justice background (i.e. police, probation) who were involved in the research and thus may be more sensitive to this issue. This issue does warrants further research.

Research Question 4: A support group for families of patients with forensic mental health needs would be beneficial. It was hypothesised that all three groups would endorse this statement with the probability that it would be of more significance for the family group.

Support groups for families were identified as a service intervention that would assist families in supporting a patient through treatment. This view also emerged from the previous study. Although, as expected, the family group endorsed it more so than the professional group, who endorsed it more than

the patient group, the group differences were not significant. However, this points to a gap in current service delivery within the Southern Health and Social Care Trust. Families appear to be an important resource for professionals to engage with, especially in the areas of risk management and rehabilitation of forensic patients. Perhaps this approach should be incorporated into existing models, such as 'What Works' and 'Risk-Need-Responsivity'.

Research Question 5: In treatment there should be equal focus on offending needs, mental needs and the development of life skills. It was hypothesised that all three groups would endorse this statement with the patient and family groups more likely to place emphasis on its importance.

The three groups did not differ from each other with regard to this research question. For patients, the ability to access accommodation and engage in pro-social activities appears to be as important as engaging in group therapeutic interventions designed to address their offending behaviour. Ogloff and Davis (2004) suggest that providing an offender with employment skills may reduce their need to offend because they could find meaningful work. Niven and Olagundoye (2002) highlighted the importance of accommodation and found that 31% of prisoners with an address on release got into paid work, compared to 9% of those who did not have housing on release.

An important development in the rehabilitation of offenders' is the 'Good Lives' model (Ward, 2002), which offers a goal-driven and positive approach to

reducing re-offending by focusing on an individual's needs, preferences, strengths, and competencies.

Research Question 6: There should be a 'stepped down' facility between secure environment and community living. It was hypothesised that the professionals would be the only group to endorse this statement.

The need for a 'stepped down' approach between secure living and community living was advocated strongly in the previous study, with professionals having the most to say in favour. The more in-depth exploration in the current study indicated a statistically-significant difference between groups, with the professional group (as expected) endorsing the statement more than the family group, who endorsed it more than the patient group. This is an unmet need in Northern Ireland that requires attention and policy input. The findings of this study are reflective of a wider issue concerning the reintegration of high-risk offenders from secure to community living. This is an issue that warrants further research.

Summary

There were no significant differences between the three groups with regard to the theme of 'treatment interventions'. The results of this study generally echo those of study one, focus groups. All three groups identify offence-focussed therapeutic groups as an important intervention. Support for the family is also highlighted as an identified need. The 'Good Lives' model is reflected through the three groups endorsing the need for non-offending interventions, such as targeting a person's emotional wellbeing and ensuring the development of life skills.

Treatment Responsivity

Research Question 1: The forensic patient's family plays an important role in motivating and encouraging a person to engage in treatment. It was hypothesised that all three groups would endorse this statement with the family group more likely to do so than the other two groups.

There is a general lack of research on the role of the family in relation to treatment engagement. However, in both the present and previous study the family has been highlighted as having significant influence on a patient's treatment. In this study there was no statistically-significant difference between groups regarding the important role the family play in motivating and encouraging a person to attend treatment. Ward (2007) makes an interesting point when he states that some of the most responsive treatment interventions are non-correctional, such as volunteer-driven approaches that are designed to support high-risk offenders released without formal supervision or treatment. If these interventions 'work' successfully, it may well be appropriate to look beyond purely 'professional approaches' and incorporate others, where appropriate, including the family.

These findings are consistent with Maruna's research on desistance in offending, where it is reported that offenders value practical support more than any type of intervention. Therefore, it may be appropriate for staff working with offenders to adopt a more holistic approach, not only focussing on offending needs but also assisting with more practical needs, such as employment and housing, and including the family where deemed appropriate.

Unfortunately, the success of family interventions appears to be under-evaluated, according to Sapouna, Bisset, and Conlong (2011). This is despite strong evidence that robust family relationships can result in sustained abstinence from offending, (Healy, 2010). Positive results have been reported for family therapy, family empowerment, and allied therapeutic approaches when working with young people who have committed more serious offences (McGuire, 2002). Early intervention is therefore important when it comes to bringing the family on board.

Research Question 2: Professionals have an important role to play in motivating a person to engage in treatment. It was hypothesised that all three groups would endorse this view.

As with the previous research question, the three groups did not differ with regard to the role professionals play in motivating a person to engage in treatment. The 'Good Lives' model highlights the importance of 'therapy style' when motivating offenders to change behaviour (McMurran and Ward 2004). It is argued that therapists should develop styles that will motivate offenders to change, such as multi-modal, active, participatory programmes. Recent studies, (DeMatteo, et al., 2010) indicate that adherence to risk/need models does reduce recidivism. The findings from both the current and previous studies suggest that with regard to treatment responsivity the professionals are functioning within these models. Research investigating reconviction rates would be useful as present research suggests that adherence to such models has a positive outcome.

Summary

The findings from the present study were consistent with the previous study in that all three groups endorsed the importance of treatment responsivity when engaging with mentally-disordered offenders in treatment. All three groups rated the statement positively (that both professionals and family members have important roles to play in motivating a person to engage in treatment). The research literature indicates that it is only those offenders who are sufficiently motivated to change and are optimistic about the future that will manage to desist from offending. Therefore, interventions are more likely to be successful if they target motivational factors and provide a sense of hope McMurran, (2002).

Collaboration and Support

Research Question 1: Transition services between the hospital and the community for forensic patients need to be improved upon. It was hypothesised that professionals would endorse this statement but that patient and family groups may not be aware of problems in this area.

The findings indicated a statistically-significant difference between groups, with the professional group more likely to agree with the statement than the patient and family groups. These findings are supportive of the above hypothesis. The Bamford review for Northern Ireland (2006) states that community forensic services should develop specific models and structures and agreed methods of working with interconnecting services. Interconnecting services are those that individuals with forensic mental health needs can benefit from or move through, for example, moving from a prison or psychiatric

ward to supported or independent living. Research undertaken by Tony Ward in the 'Good Lives' model advocates treating the 'whole person'. This means looking at the person holistically, for example taking into account their living environment and the different services they may require at different stages in their treatment. This is also reflective of the 'Risk-Need-Responsivity' model (Andrews and Bonta, 1995), which focuses on providing the right treatment at the right time, whether it is in hospital, prison, the community, or transitioning between services.

Research Question 2: The forensic team need to increase awareness of the service and what they do. It was hypothesised that professionals would endorse this statement but that the patient and family groups would not be aware of problems in this area.

The findings in this study show a statistically-significant difference between groups, with the professional and family groups more likely to agree with this statement positively than the patient group. The importance of team work and awareness of what teams do has been shown in many different studies; Baker, Salas, Barach, Battles, and King, (2007); Manser, (2009), and Bower, Campbell, Bojke, and Sibbald, (2003) stated that good team work can help reduce patient safety problems and improve team members' moral, as well as team viability (the degree to which a team will function over time). This research supports the above hypothesis in that professionals and families are highlighting the importance of teams, particularly in terms of knowledge of what the forensic team does. The Bamford Review for Northern Ireland (2006) highlights the importance of accessibility for forensic teams. In order for a

team to be accessible clients need to be aware of what the service can and does offer. The results of this study indicate that this is not the case. This is an area that requires development and improvement in the Southern Health and Social Care Trust.

Research Question 3: Relationships between the forensic and other teams could be improved upon. It was hypothesised that the professionals would endorse this statement but that the patient and family groups would not be aware of problems in this area.

Research highlights the importance of collaboration and support amongst teams when working with mental health patients and offenders (Bryne and Onyett, 2010; Department of Health, 2005). The Bamford Review for Northern Ireland (2006) stresses the importance of good team work and interagency working when working with offenders in the community. In this study there was a statistically-significant difference between groups, with the professional and family group more likely to agree with this statement than the patient group. As with previous findings, this again highlights the important role the family play in a patient's care. In this case they appear to be more aware than the patient group of issues such as team dynamics.

Research indicates the importance of team dynamics with regard to patient safety. The World Health Organisation's report concerning human factors on patient safety (2009) states that in the world of healthcare, very little training in human factors is provided to staff, unlike the other safety-critical industries. Leonard, Graham, and Bonacum, (2004) state that communication failures are the leading causes of inadvertent patient harm. Reader, Flin, Lauche, and

Cuthbertson, (2006) state that some of the key problems relate to the following: shift or patient handovers; the quality of information recorded in patient files, case notes, and incident reports; status effects inhibiting junior staff from speaking up, and difficulties of transmitting information within and between large organisations.

Summary

The results of the present study build on the previous study's findings on the need for more collaboration and support between professional disciplines and teams. Within each instance the professional group was more likely than both the patient and family groups to endorse statements relating to increased communication between professional teams. In addition, for each statement, the family group were more likely to endorse it than the patient group. This is perhaps to be expected as the patient group would have less exposure to working-relationship issues between teams in comparison to both the professional and family groups. However, the fact that the family group are in agreement about the need for improved working relationships is concerning in that it suggests that they are being exposed to disagreements or differences of opinion between professionals. This has important implications for service delivery, and warrants further research.

Family Involvement and Support

Research Question 1: The family plays a crucial role in the management of a forensic patient. It was hypothesised that all three groups would endorse this statement, particularly the family group.

The findings endorse the importance of family involvement in a patient's treatment. The three groups did not differ significantly from each other with regard to these viewpoints. This concurs with the results of the previous study, which emphasised the important role the family play. Professionals, patients, and family members all see the family as having a crucial role in a patient's treatment.

The 'What Works' and 'Risk-Need-Responsivity' models both advocate the provision of treatment that is responsive to an individual's needs. Incorporating the family, where appropriate and where consent is given, is an important addition to a patient's risk management plan.

The need for family involvement has been highlighted through the findings of study one and study two. It is also demonstrated through research in both prison and community populations. The Urban Institute (Visher, La Vigne, and Travis, 2004) found that offenders interviewed both before and after release from Maryland prisons had expectations that family members would provide housing and support them financially. In general, these expectations were met. The study also revealed that 63% of 200 prisoners stated their families were a source of support for them, 88% wished they could do more for their families, and 56% wished they knew how to repair the bridges they had burned with their families. The Maryland Department of Public Safety and Correctional Services (DSPCS) responded to this research, and now include family involvement as one of their target domains for policy and programming.

Research Question 2: More support should be offered to the family of patients with forensic needs. It was hypothesised that all three groups would endorse this statement, particularly the family group.

The findings endorse the importance of family involvement in a patient's treatment. The three groups did not differ significantly from each other with regard to these viewpoints. This concurs with the results of the previous study, which found that the family group advocated the need for a support group that was specifically tailored for a patient's family, providing advice and guidance on how to risk manage a forensic patient.

Existing research acknowledges the important role families have to play in a forensic patient's treatment. Working with families has been identified as important in helping to prevent relapses in mental illness, and indeed may be beneficial, within a forensic setting, in lowering risk. (Richards, Doyle, and Cook, 2009). This being the case, families should be offered support in their role in patient treatment.

Summary

All three groups appear to see the family as a critical factor in the risk management of a forensic patient. How a service can support families to do this, and whether there are any ethical considerations in terms of responsibilities and who does what, is worthy of further consideration. However, although work with families in this context is worthwhile, it has been identified as being rarely available, and furthermore staff do not feel skilled in providing such interventions (Absalom, et al., 2010). This has important

implications for service delivery, particularly, if identified as an intervention that may reduce risk.

Psychological Wellbeing

Research Question 1: Social outlets and relationships help promote and offence free life. It was hypothesised that all three groups would endorse this statement, but more so the patient and family groups.

The results of the present study build on the previous study's findings relating to the importance of the 'Good Lives' model as an approach for the psychological wellbeing of forensic patients. Though, as hypothesised with regard to the statement 'Social outlets and relationships help promote an offence free life', the patient group gave a more positive endorsement than the family group, who in turn gave it a more positive endorsement than the professional group.

Previous research indicates that key life events such as acquiring a stable relationship, employment, and completing education decreases the likelihood of offending by adding structure to offenders' lives and acting as a source of informal monitoring and emotional support (Sapouna, et al., 2011).

Desistance studies such as that undertaken by McNeill and Weaver (2010), found that rebuilding ties with family, friends, and the wider community were important indicators of desisting from crime. The research literature also indicates that accessing 'primary human goods' such as relationships (Ward 2002) not only helps promote an offence-free life, but also facilitates wellbeing and improved mental health. Ward goes on to say that because human beings

are mutually interdependent they can only achieve 'human good' if others provide them with the necessary social, physical, and psychological nourishment. Again, this highlights the importance of a positive network of peer support, whether through friendships, social outlets, family, or professionals.

Research Question 2: Persons with a mental illness and forensic history are fearful of their illness. It was hypothesised that the patient and family group would endorse this more than the professional group.

The findings indicated a statistically-significant difference between groups and a post-hoc comparison of means indicated that the family group were more likely to agree with this view than the other two groups. This reflects the degree of insight the family have regarding the impact of mental illness and offending on a person. Again, it also highlights the important role they can play in supporting a person with a mental illness and forensic history. The conclusion one can draw from this is that more intervention and support in helping people understand their mental illness is required. As Ward and Brown (1984 p 244) point out: 'at the end of the day most offenders have more in common with us than not and like the rest of humanity have needs to be loved, valued, and to function competently, and to be part of a community'.

Research Question 3: Families of people with a mental illness and forensic history are fearful of the impact on the family. It was hypothesised that the patient and family group would be more likely to endorse this statement than the professional group.

The findings in the study did not indicate any significant difference between groups for this view point. The three groups appear to be in agreement regarding the stigmatisation and fear still present for those diagnosed with a mental illness. Offenders and people with mental illnesses are often marginalised by society. Mental illness still generates fear within those who have a diagnosis and also for their families. It is also important to re-emphasise the positive role that the family plays in motivating a person to engage in treatment, as identified previously in this research and other studies (Healy, 2010). If families are fearful of a person's mental illness then this may impact on their ability to motivate an individual, again highlighting the importance of support for families of people with mental illness and forensic needs.

Summary

The findings from this study with regard to psychological wellbeing highlight the fear that mental illness and offending instils in both patients and families. In this study the families endorsed the view more positively than the patient and professional groups. As already stated, this once again emphasises the important role the family can play in supporting and rehabilitating a person with mental illness and offending behaviour.

Public Perception and Awareness

Research Question 1: People who have a mental illness and forensic history are perceived differently by others. It was hypothesised that the family and patient groups would be more likely to agree with this statement.

There was no statistically-significant difference between the three groups with regard to this statement.

Research on stigma, mental illness, and offending behaviour highlights how stigma impedes not only successful reintegration into the community, but also the person's ability to obtain a job or accommodation, and ultimately therefore their rehabilitation (McAlinden, 2005). In forensic populations there appears to be the 'double stigma' (Hartwell, 2004) of not only having a mental illness, but also an offending history, and it is this which creates barriers to receiving community services. This has important policy implications in terms of resource allocation, treatment, and community reintegration. Therefore, one conclusion to be drawn is that it is important when working with offenders to empower them, so they develop self-efficacy that will assist in motivating them to change and thus help develop a strength that will overcome barriers such as stigma.

Caverley and Farrall (2011) report the examples of offenders who feel good about themselves when invited by local drug agencies to give a talk about their experiences of coming off drugs. This provided a sense of reward and achievement, reminding them of the benefits of staying away from crime. For the public it also demonstrates the value of treatment interventions and working with offenders. Hopefully, this goes some way towards educating the public on what works, and demonstrates that offenders can change and desist from crime.

Research Question 2: Public perception and awareness of mental illness and offending behaviour has a negative impact on treatment and

recovery. It was hypothesised that the family and patient groups would be more likely to agree with this statement.

There was no significant difference between the three groups with regard to this statement. The results of this study highlight that all three groups report the impact of negative public perception on mental illness and recovery. People have a false perception that people with a mental illness are dangerous, and this can impact on issues such as placement in the community, (Cowan, 1999). Many arguments against the placement of community mental health facilities revolve around issues of safety, such as risks posed to young children, (Cowan, 1999). This flies in the face of rehabilitative models such as 'Good Lives' and 'What Works', which advocate the importance of acceptance for offenders and treating the whole person rather than focusing purely on the illness or criminogenic needs.

Research Question 3: The public need to be educated more on mental illness and offending behaviour. It was hypothesised that the family and patient groups would be more likely to agree with this statement.

The findings indicated that the groups did not differ from each other with regard to this viewpoint. Given the reported level of stigma and fear expressed by the family and patient groups it would seem natural that more work is undertaken on public education regarding mental health and offending. Education has been linked to the views of mentally ill people, with those who have higher levels of education having more positive views (Chou and Mak, 1998; Ojanen, 1992).

Research Question 4: The religious or cultural divide in Northern Ireland has had a negative impact on the recovery and rehabilitation of people with a mental illness. It was hypothesised that the religious divide in Northern Ireland is likely to have a negative impact on rehabilitation and recovery for people with a mental illness and offending behaviour.

The groups differed significantly with regard to the rather negative impact of the Northern Ireland cultural divide on the recovery and rehabilitation of people with a mental illness. The professional group were more likely to positively endorse this statement than the patient and family groups. This could be because professionals feel more comfortable recording their views on religion and politics, particularly with another professional, compared to the patient and family groups. This issue is worthy of further exploration.

Research Question 5: There is still stigma attached to mental illness and offending behaviour. It was hypothesised that the family and patient groups would be more likely to endorse this statement.

Research studies also support this hypothesis. Philip Zimbardo (1972), in his Stanford Prison Experiment, deindividuated the prisoners by assigning numbers instead of names, dressing them up in the same clothes and hiding their hair under nets. According to Zimbardo, people do not feel the need to be just towards an individual who has been deindividuated. Unfortunately, people who are mentally ill and have an offending history are doubly stigmatized, due to both their mental illness and their criminal past. People who are mentally ill are often incorrectly perceived to be dangerous (Rabkin, 1980). This is partly due to the stereotypes portrayed by the media, which

likely influences peoples' views. In a study conducted by Thornton and Whal (1996), undergraduate students in a psychology class who were asked to read a newspaper article about a murder committed by a psychiatric patient were less likely to accept mentally-ill individuals in the community, and were more fearful of those patients than students who read another article on health issues not involving mental illness.

Summary

Results of the present study again reinforced findings from the previous study, with all three groups agreeing with the view that there is still stigma attached to mental illness and offending behaviour, and therefore more education for the public is required. There was no statistically-significance difference between the groups on this issue, however there is some difference between groups with regard to the negative impact of Northern Ireland culture on treatment and recovery. As stated earlier, it will be interesting to explore this issue further in study three.

Living Environment

Research Question 1: People with forensic mental health needs require a living environment that is specific to their needs. It was hypothesised that all three groups would agree with this statement.

The findings indicate that all three groups agree with this statement. Langan and Levin, (2002) state that almost every offender that goes to prison will, at some point, be released back into the community. Whilst some may not go on to re-offend after release, the evidence suggests that many do (Ministry of

Justice, 2010, 2011). For example, in a study of US prison releases, two-thirds were re-arrested within the first year following their release (Beck and Shipley, 2001; Langan and Levin, 2002).

Research suggests that prisoners themselves believe that having a place to live once released from prison is an important risk management factor (Williams, Poyser, and Hopkins, 2012). A study of transitional care in Scotland found that housing problems made it more likely that offenders with drug problems would re-offend on release (McRae, McIvor, Malloch, Barry, and Murray, 2006). Harper and Chitty (2005) suggest that finding stable accommodation increases the chances of employment, and therefore desistance from offending. Interestingly, researchers in Europe and North America argue that it is more effective to re-house offenders in mainstream accommodation with security of tenure rather than hostel accommodation, which can foster the development of networks between offenders, thus encouraging a criminal lifestyle (Shapland, Bottoms, Farrall, McNeill, and Robinson, (2011).

Research Question 2: People with forensic mental health needs require additional support in their living environment. It was hypothesised that all three groups would agree with this statement.

The findings indicate that the three groups did not differ from each other with regard to this statement.

Crime Prevention through Environmental Design (CPED) is a multidisciplinary approach deterring criminal behaviour through environmental design.

Originally coined by criminologist C. Ray Jeffery in the 1970s, it is based on modern learning theory and emphasises the role of the physical environment in the development of pleasurable and painful experiences for the offender that would have the capacity to alter behavioural outcomes. The CPED approach has since been refined and as of 2004 is based solely upon the theory that the proper design and effective use of the built environment can reduce crime, reduce the fear of crime, and improve quality of life. The built-environment implementations of CPED seek to dissuade offenders from committing crimes by manipulating the built environment from which those crimes proceed, or in which they occur. The six main concepts according to Moffat (1983) are territoriality, surveillance, access control, image/maintenance, activity support, and target hardening. Moffat argues that applying all of these strategies is key when trying to prevent crime in any neighborhood.

It would therefore be judicious for professionals to invest time in helping people access appropriate accommodation and for Public Services to allocate sufficient resources to make this happen.

Research Question 3: In Northern Ireland there is a negative bias towards locating people with forensic mental health needs in supported living environments. It was hypothesised that all three groups would agree with this statement.

The findings indicate that the three groups did not differ from each other with regard to this statement. Tompson and Spencer (2013) suggest that the neighbourhoods where prisoners are most likely to return tend to be

disadvantaged urban areas, often lacking in economic resources and community-based support services, which are characterised by low social cohesion and poor informal social control, and often have high crime rates (La Vigne and Mamalian, 2003; La Vigne and Thomson, 2003). They go on to say that the areas where they are released to can certainly be thought of as conducive to crime. Tompson and Spencer (2013) argue there is not enough consideration given to the ecological risks presented to prisoners when professionals conduct their risk assessments. In this study it would appear that all three groups feel that 'living environment' is an important consideration. In Northern Ireland where a person is settled can be a huge risk factor in terms of religion and the impact of ongoing paramilitary-type activity in their area.

Summary

The results of the present study again reinforced findings from the previous study regarding the importance of an appropriate living environment for people with forensic mental health needs. Although there was no significant difference between the groups, the family group were more likely to endorse the statement (that there was a need for more support for patients in their living environment) in comparison with professionals, who in turn were more likely to endorse it than the patients.

Professional Characteristics

Research Question 1: Gender influences the working relationship between patient and professional. It was hypothesised that all three groups would be likely to disagree with this statement.

Research Question 2: Cultural background influences the working relationship between patient and professional. It was hypothesised that all three groups would be likely to disagree with this statement.

Research Question 3: Religion influences the working relationship between the patient and professional. This statement was applied only to the professional group.

There was a statistically-significant difference between the three groups for statements one and two. The results of the present study reinforce the findings from the previous study concerning the importance of professional characteristics when working therapeutically with patients. Interestingly, the gender and cultural background of the therapist was viewed as important. The professional group were more likely to endorse gender as bring a factor that influences the working relationship between therapist and patient in comparison with the patient and family group. This may be because within the Southern Health and Social Care Trust the majority of key workers are female. In terms of cultural background, the family group were more likely to endorse this as being a factor that influences the working relationship between therapist and patient in comparison with the professional and patient group. As stated earlier Pies and Geppert (2013) suggest that numerous transference/counter-transference issues can arise when there is a mismatch between the religious convictions of therapist and patient. In this study the religion of the three groups was not disclosed; this would be interesting to review for future research.

Research Question 4: Personal qualities such as warmth, empathy, rapport and trust are as important as technical skills when working with someone with forensic mental health needs. This statement was only applied to the professional group. It was hypothesised that this group would endorse the statement.

The professional characteristics of staff have been widely cited in research literature, particularly in the context of working therapeutically with offenders. For both male and female offenders qualitative research suggests that a good working relationship between the offender and his or her supervisor can act as a catalyst for change, especially when the offender has already taken the decision to give up crime (Healy 2010). Sapouna, Bisset and Conlong (2010) state that overall studies report more benefits in cases where the supervisor respects and fosters the offender, focuses on strengths as well as criminogenic needs and risk, and draws up an action plan in consultation with the offender. They go on to say that when interviewed about the quality of supervision offenders often cited empathy, respect, flexibility, the ability to listen, and professionalism as the defining characteristics of an effective working relationship that triggered change. A number of studies have focussed on the therapeutic alliance between therapist and offender, stating that it can be as important as the treatment intervention (Marshall et al., 2003). Overall, research suggests that re-offending is likely to reduce when a 'working alliance' with the professional is developed. These findings point to the need to invest in interpersonal training for professionals working with offenders. This issue is worthy of further exploration.

Governance

Research Question 1: Organisational constraints impede on the rehabilitation of offenders. It was hypothesised that professionals would strongly agree with this statement.

Research Question 2: Improvements need to be made to forensic services to ensure a whole systems approach so that a 'silo mentality' when working with patients is avoided. It was hypothesised that professionals would be more likely to agree with this statement.

There was a statistically-significant difference between the groups for this theme, with the professional and family groups more likely to endorse the statements than the patient group. A study by Aiken, Clarke, and Sloane, (2002) indicated that the organisational climate in hospitals, and specifically organizational support for nursing care that is potentially modifiable, has been an undervalued determinant of poor patient outcomes as well as nurse recruitment and retention failure. These preliminary findings from the International Hospital Outcomes Study underscore the importance of managerial support for clinical care services and providers, namely nurses.

Summary

Organisational constraints impact on the ability to deliver interventions to best practice. Overall, this research has identified a number of important themes for what works best with mentally-disordered offenders. Unfortunately, these treatment interventions are only as good as the ability of a service and

organisation to adequately resource and effectively implement them. The area of governance is further explored in the third study.

5.7 Conclusion

The findings of the second study build on the findings of the first study; both studies are supportive of existing research in the area of offender rehabilitation and demonstrate the effectiveness of the three models, 'What Works', 'Risk-Need-Responsivity' and 'Good Lives', with a mentally-disordered offender population. The 'Good Lives' model in particular appears to have the most significance in terms of what works best for the family and patient groups.

The results of study two indicate areas of limitation and significant difference that warrant further investigation as follows:

Risk Management

In particular, the role of the key worker, which in the current study was endorsed more by the patient and family groups than the professional group. Further exploration regarding the importance of the key worker to these groups may highlight why there are differences of opinion.

Attention to individual needs in a treatment and risk management plan was also endorsed more by the patient and family groups. Why this is more important to the patient and family groups requires further examination. The impact of being risk-averse with regard to rehabilitation was endorsed more by the professional group. The impact of the Northern Ireland culture on risk management was endorsed more by the professional group, as was the

importance of a 'step down' approach between hospital/prison and community living. These areas warrant further exploration.

Treatment Intervention and Treatment Responsivity:

The importance of the 'Good Lives' model with regard to reducing re-offending and improving psychological wellbeing was a positive finding. Therapeutic groups were strongly endorsed in both the first and second study, therefore their specific benefits are worth exploring in more detail. The provision of a 'step down' arrangement is another area for more in-depth consideration.

Public Perception and Awareness

The impact of the Northern Ireland culture on wellbeing was endorsed more by the professional group, however with regard to professional background, the patient and family group felt that the cultural background of a professional matters. This issue is worthy of more research attention.

Family Involvement and Support

This was a theme strongly supported in the first study and endorsed by all three groups in the second study. Strong emphasis was placed on the need for a family support group. What this might look like, and other possible support mechanisms are worthy of further exploration. The results of study two evidence an endorsement of many of the focus group findings. However, they also highlight areas of significant difference, particularly between the three groups, which will be further explored in study three using semi-structured interviews.

CHAPTER 6: STUDY THREE

THE VIEWS OF CLIENTS, FAMILIES AND STAFF IN RELATION TO

STRUCTURE, FUNCTION AND EFFICACY OF

FORENSIC MENTAL HEALTH TEAMS

6.1 Introduction

The objective of the current study was to follow-up key issues derived from studies one and two. These are set out below:

- *Risk Management:* In study one the role of the key worker in a patient's risk management and treatment plan was strongly endorsed by all three groups. However, in study two the role of the key worker was endorsed more so by the patient and family groups. The therapeutic relationship between patient and therapist has been identified in the research literature as one of the most critical success factors in terms of treatment and risk management (Marshall, et al. 1999; Birgden 2004; Andrews, 2001). The differences between the three groups are therefore worthy of further exploration in study three;
- *Treatment Intervention and Treatment Responsivity:* In studies one and two, all three groups highlighted the importance of treatment interventions that are tailored to the needs of patients. Therapeutic offence-focussed groups were endorsed strongly. This supports the research literature which highlights that using structured offending programmes in community settings can reduce recidivism, (McGuire,

2002). Exploring the specifics of what works well within treatment, from the perspective of service users, would be of benefit to this research;

- *Public Perception and Awareness:* In studies one and two the role of stigma regarding mental health and offending behaviour was identified as an ongoing, significant issue, particularly for patients and families. Research highlights the negative impact of public attitudes on people with mental health conditions and how this can adversely affect their recovery (McAlinden, 2005; Hartwell, 2004; Caverley and Farrall 2011). There were some differences between groups with regard to the role of the Northern Ireland culture on 'wellbeing' that warrants further exploration. The patient and family groups felt that the cultural background of professionals can impact on the therapeutic relationship. Research does indicate that a person's religion or culture can influence the professional/patient relationship (Constantino, et al., 2011) and patient attachment style (Levy et al., 2011). The aim of study three is to explore and compare further the attitudes of the three groups with regard to the impact of Northern Irish culture on treatment and rehabilitation;
- *Family Involvement and Support:* The positive role that family can, and want to, play in a forensic patient's risk management has been illustrated through this research. Studies one and two both emphasised this engagement approach, and existing research also highlights the importance of positive family support (McNeil and Weaver, 2010;

Deakin and Spencer, 2011; Sampson and Laub 1993). What family support might look like is worthy of further exploration in study three.

Study three will also explore the remaining themes: professional characteristics, living environment, governance, and collaboration and support. Although there were no significant differences in these themes they remain worthy of further investigation.

6.2 Aim

Aim: To explore the views of patients, families and professionals, in relation to the structure, function, and efficacy of community forensic mental health teams.

Within each theme individual aims related to the research questions were established. These are set out in the results section and in Appendix 18.

6.3 Methodology

Design

The interview questions were set out in a tabular format under the ten themes that were identified in study one and further explored in study two. The questions focused on those issues where significant differences were found in the views of the three groups in study two. For example, with regard to risk management, the results of study two indicated that there were significant differences in the views of participants in the three groups as to the role of the key worker. Hence, in order to gain further insight into why views might differ, the interview was designed to probe this specific issue further.

(See Appendix 18 for semi-structured interview questions and related study aims).

Subject Group Profiles

Each of the three subject groups were heterogeneous; their profiles are detailed in the following tables.

Six to eight people were identified within each group for interview. In terms of the professional group a representative from each specific professional category was selected: psychologist, psychiatrist, nurse, social worker and probation officer. Participants were selected on the basis of accessibility and availability to participate in the interview process. Prior to the interview the purpose was fully explained and consent was secured.

Table 1: Patient Group

Gender	Diagnosis	Age	Offence
Male	Personality Disorder	22	Sex Offending
Male	Depression	41	Sex Offending
Male	Paranoid Schizophrenia	34	Violence
Male	Paranoid Schizophrenia	25	Violence
Male	Paranoid Schizophrenia	39	Violence
Male	Paranoid Schizophrenia	36	Violence

Table 2: Family Member Group

Gender	Relationship to Patient	Age
Female	Wife	32
Female	Wife	31
Female	Mother	61
Female	Mother	55
Male	Father	69

Table 3: Professional Group

Gender	Profession	Age
Female	Psychiatric Nurse	32
Male	Psychologist	51
Male	Psychiatrist	49
Female	Probation Officer	43

6.4 Procedure

Pilot Group

The semi-structured interview was piloted with a participant from each group. Some minor changes were made as a result. This related to the wording of some of the research questions to ensure they were better understood by the participants.

Interview Administration

The interviews were conducted on a one-to-one basis.

The interviews were administered to the participants face to face by the same researcher across the three groups and within a four-week timeframe. Those who participated in studies one and two also participated in study 3. The programme ensured uniformity of time and questioning. Eighteen participants, six from each of the three groups, were originally selected. This was to draw out and compare differences in the three service user group perspectives. Selection was based on whether people could commit to undertaking the interviews. However, due to the availability of participants, fifteen fully engaged in this stage of the research: four professionals (psychologist, psychiatrist, probation officer, and Community Psychiatric Nurse), five family members (three parents and two spouses), and six patients were interviewed. Two professionals were unable to meet due to work commitments and one family member decided not to engage in the research process.

Interviews were digitally recorded. Hand-written notes were also taken as a supplement. All participants gave written consent to participate in this stage of the research. Participants were told that the interview would enquire about their opinions concerning the community forensic mental health team and would last for approximately one hour. They were informed that the interviews would be audio tape-recorded for data collection purposes, and that all information would be held confidentially. This approach was willingly accepted.

All interviews took place in an office within the Trust site; this location was acceptable to all the participants.

Interpretation

The completed interviews were analysed using the Thematic Analysis approach. This was the same process used as in study one, where full details are provided.

6.5 Results

The results are set out in the tables below. These relate to each of the areas of interest and research questions set out in the introduction to the study. Also shown, in separate tables related to each theme and associated research items, are comprehensive extracts from the participant responses of the three groups (patients, families, and professionals) to the research questions. Significant textual points have been highlighted to help inform the discussion. Several areas from the extracts were removed and words (names) deleted to protect anonymity.

Table 1: Risk Management

Risk Management Item	Key Issue	Question
<i>Role of the Key Worker</i>	In study two there was a statistically significant difference between the three groups with regard to their view concerning the role of the key worker with professional group less likely to agree with the importance of the	What is it about the role of the key worker in the risk management and treatment plan of a forensic patient that is important?

	key worker than either the patient or family groups.	
<p>Key Responses to Question</p> <p>There were some common responses from the three groups to this question. Regular communication in addition to trust and support were seen as important characteristics of a Key Worker. Professionals focussed on how the key worker acts as a link point between the various agencies involved in the patient's risk management plan. The family group emphasised accessibility; <i>'helps get quick interventions'</i>, <i>'always at the end of the phone'</i> and the patient group highlighted how the key worker intrinsically helps them by; <i>'making me think better'</i> and <i>'prevents me from going off the rails'</i>.</p> <p>Summary – while professionals tend to focus on practical aspects, the family members tended to focus on the usefulness of key workers for them and the client group on the therapeutic aspects.</p>		

<p>Extracts of participant responses <i>My forensic key worker plays an important role in my risk management and treatment plan ('Risk-Need-Responsivity' model)</i></p> <p>I predict that all three groups would emphasize the importance of the key worker, particularly the professional group.</p>
<p>Patients</p> <p>1...Being there, support</p> <p>2... I think keyworker already does a lot for you. Regular contact is important...They are good to help you get organised</p> <p>3.... Keeps in touch regularly particularly at the start; Makes me think better; Look forward to seeing the key worker as good support; Prevents you from 'going off the rails'</p> <p>4... Key work very essential</p> <p>5.... important to have openness and trust....allows you to open up and talk about how you feel. Someone easy to talk to...easy to communicate with</p> <p>6.... Good to get injection from. Good it I need someone to talk to</p>

Families

- 1...Good for co coordinating everything. They keep everything on track with appointments
- 2.... I felt the key worker was needed, I saw it has somebody to be there for him.....**Its good support for the person.**
- 3... It makes it easy if you're in need of intervention quickly. **Help is always at the end of the phone...help get quick interventions**...You feel like you have back up. We have had a same keyworker for so long, this helps because they know A very well.
- 4.... We see a lot of Key Worker. We thought it would have been nice to have more support

Professionals

- 1.Define the level of risk for that individual, the wider community the family.... **keyworkers role to ensure that all that valid information is recorded on the plan and that it is shared with the appropriate people**
2. On-going assessment with risk. Therapeutic work. Can help with certain medication monitoring, working alongside the consultant psychiatrist in relapse prevention
- 3...**the key worker is the link between the people who actually shares the information and actually what is going on in the case**, particularly if you're outside the organisation...
- 4... Firstly having continuity, knowing the person helps a lot. Building a relationship with them, gaining trust...**Important to have an individual care plan that is patient centred**...Need time to ventilate with your key worker, that way it gives you a better picture of the patients thinking process. Key worker is also a good support for the family.

Risk Management Item	Key Issue	Question
<i>Influence of key worker gender, age</i>	In study one there was no significant difference between the three groups with regard to the	Why do you think age, gender and religion is of little

<i>and religion on risk management and treatment</i>	role of gender, age and religion of the key worker. In study two there was a significant difference between the three groups in relation to the gender of the key worker with the professional group more likely to agree that gender influences the working relationship between patient and professional than the family and professional groups.	importance when it comes to the key worker's role in risk management and treatment?
Key Responses to Question Interview responses indicate that all three groups agree that gender, age and religion are of no importance to the role of key worker. Statements including; ' <i>of no importance</i> ', ' <i>doesn't make a difference</i> ', and ' <i>doesn't matter to me</i> ' reflect this.		

Extracts of participant responses <i>The gender, age and religion of forensic key worker influences risk management and treatment</i> I would be surprised if gender, age or religion was a significant factor in influencing risk management and treatment.
Patients' <i>of no importance</i> ', ' <i>doesn't make a difference</i> ', ' <i>doesn't matter to me</i> ' (key worker's gender, age and religion on risk management and treatment not relevant)
Families (key worker's gender, age and religion on risk management and treatment not relevant)
Professionals (key worker's gender, age and religion on risk management and treatment not relevant)

Risk Management Item	Key Issue	Question
<i>Risk assessment and treatment plan</i>	In study two all three groups rated this as an important issue.	What do you see as important in a patient's risk assessment and treatment plan?

Key Responses to Question

Interview responses indicate that professionals emphasise the importance of identifying risk levels, maintaining good records and understanding a person's offending history. For the patient, having someone to talk to, participating in therapeutic groups, in addition to having access to social outlets, were seen as important. The patient group also felt that having the Key Worker visit you in your own home is beneficial; *'seeing me at home, I open up more and talk about my problems'*. The family group identified groups as good; however, they felt follow up work is needed for the patient post group activity. They also stressed the importance of family involvement; *'need to know what's going on'* particularly in relation to identification of risk areas, and *'knowing what steps to take if something did happen'*.

Extracts of participant responses *Risk assessment and treatment plan is important ('Risk-Need-Responsivity' model)*

I would predict that professionals would see this as very important and to some extent families and patients

Patients

1... I'm not sure

2... That everyone knows what is going on

3....Treatment plan has been good; Good Thinking Skills Group is important; Having a key worker; **People coming out to see me**

(professionals) in my home environment, feels like another friend and helps you open up more and talk about your problems

4.... It is important to know what is in place to manage risk

5.... For me it's about addressing the mental health issues first. Keeping yourself well mentally....a social outlet, having someone to talk to helps.

Families

1...Need to involve family as well. That is if the family want to be involved

2....The family really needs to know what is going on....They need to be told things...need to know what steps to take if something happens

3... That the actual risk areas are identified and looked at. Therefore if something did happen everybody knows what steps to take

4..... Well we thought the anger management course was very good for A

....follow up talked about but so far that has never happened.

Professionals

1 ...risk is about firstly identifying it and being able to modify it if that's possible... need to check the vulnerability of the individual themselves their intellectual capacity.predictive of where this individual might offend again.....vulnerability, for example, in terms of paedophilia where is this person going to live.

Risk Management Item	Key Issue	Question
<i>Being risk-averse</i>	In study two there was a significant difference between the family and professional groups with regard to the negative impact of being risk-averse on risk management and patient rehabilitation, with the family	How does playing safe or being risk-averse impact negatively on a patient's risk management and treatment plan?

	group more likely to disagree than the professional group.	What can be done to change this?
<p>Key Responses to Question</p> <p>The family and professional groups had the most to say on this issue. Professionals voiced concerns around the logistics of risk management and the amount of paperwork involved when undertaking risk assessments. The family group emphasised obtaining a balance in risk and rehabilitation. This was also raised by the patient group; <i>'I just want to live a normal life'</i>. The difference between the groups in this area was around the process of risk assessment. The professionals focussed on the personal impact of completing risk assessments; <i>'too much paper work'</i>, whereas, the patient and family groups highlighted the impact on rehabilitation indicating that risk assessments are like <i>'a ball and chain around my neck'</i> (patient).</p>		

<p>Extracts of participant responses <i>Being risk-averse has a negative impact on risk management and patient rehabilitation (not asked of all the patients)</i></p> <p>I would predict that professionals would agree with this statement</p>
<p>Patients</p> <p>4....professionals offer</p> <p>5.... In a way you feel like you can't move forward sometimes....probation is always there, hostile felt like I was in a prison like a ball and chain round by neck....For example I wanted to go to the gym, but probation won't allow me. I understand and realise the restrictions are there for a reason, but at times you just want to be able to move and live a normal life.</p>
<p>Families</p> <p>1...I suppose it could hold them back from getting out and into the real world. Good to have a happy medium</p> <p>2.... ...Maybe not enough talking to the patient and their family.</p>

3.... No I don't. Good relationship with nurses/consultants means that I know when to phone when perhaps I'm not able to manage things at home. The fact that I'm here, and it's a stable family unit means there is good support for A. We help reduce the risk. They know I will phone if things deteriorate.

4.... In a perfect world, there would be a good balance of both. But I suppose it depends on each individual situation

Professionals

1...you can minimise the actual degree of risk because you don't want to highlight something... things that people tell you that you think oh I don't want to open up that ...if risk-averse and you don't record these things then the risk doesn't go away ... create greater higher level of risk to the patient and to the wider community and to the team working with the person.

2...I think we are in a culture...everyone is trying to share the risk with other professionals to try and reduce risk, and often the patient can pick that up....can affect the therapeutic alliance. One way would be new policies for patients to have more ownership of their mental health....It's quite difficult in the client world, litigation and there is professionals perceived as a blame culture, and the media... I think everyone is thinking of negatives and negative risk, the things that can go wrong and about the consequences

3....to change this would be if there's acknowledgement in sharing the responsibility of any case....a good thing is when the risk should be discussed quite openly among all the agencies involved, and in terms of managing risk I think the fact its shared among agencies and that such agencies work together on the case I think this stops being too risk-averse. Sometimes there is just too much paperwork

4... I think you always have to be...Risk is always the first thing that comes into your head...Risk assessment when done right can give you good guidance....In my view they help protect my professional body, and safe guards me and the patient. With any risk management better to

have a **holistic approach**....good to liaise with other professionals, and this widens your role as a practitioner...

Risk Management Item	Key Issue	Question
<i>Impact of NI culture on risk management</i>	In study two there was a significant difference between the three groups in that the professional group were more likely to agree about the impact of NI culture on risk management than either the patient or family groups.	In what way does the Northern Ireland culture and equality legislation influence a 'play safe' culture?
Key Responses to Question <p>When this was further explored through interview all three groups emphasised the importance of 'equality' for patients. For example, <i>'manage the risk and the fairness of it' (professional) and 'shouldn't make a difference' (family)</i>. The different findings between study two and three might reflect uneasiness in discussing 'equality and culture' in Northern Ireland.</p>		

Extracts of participant responses *The NI culture and high awareness of equality influences my risk management plan*

This is an unknown and would want to explore the significance of the NI culture for people

Patients

1.... I don't know

2.... Nothing, apart from lack of funding. You know Northern Ireland doesn't have the same budget for mental health services.

3.... No
Families 1. I don't think it shouldn't makes any difference... 4. I don't think so. My view that both community should get same service.
Professionals 1 -The play safe culture, I think again is about the risk aversion and the kind of defensive practice that we would employ...we have an overriding duty where risk is there to manage the risk and not the fairness of it...

Table 2: Treatment Interventions

Treatment Intervention Item	Key Issue	Question
<i>Therapeutic groups</i>	In study two all three groups agreed that this was an important area of service delivery – and there was no significant difference between groups.	Why and in what way are the forensic therapeutic groups important?
Key Responses to Question Interview responses highlighted a strong belief, particularly from the professional group, that people with offending behaviour can change; <i>'the patient can change'</i> and <i>'people can change through therapeutic group work'</i> . It was also advocated from both the patient and family groups that fundamentally there needs to be a <i>'willingness' to change on the patient's part and that 'therapeutic groups only work if the patient is willing to engage'</i> (professional). All three groups agreed that groups enable the mentally-disordered offender to gain a better understanding of their offending behaviour. For example; <i>'helps see the consequences of offending behaviour'</i> (professional), <i>'increases understanding of behaviour'</i> (family) and <i>'helps me with problem solving'</i> (patient). The social aspect of groups in terms of meeting people with similar problems		

was also emphasised as important; '*gets me out of the house*' (patient). In summary, real value was placed on therapeutic groups, not only as a tool for reducing risk through increased understanding of offending behaviour, but also as a vehicle for intrinsic change for the better.

Extracts of participant responses *Patient participation in forensic therapeutic groups is important for an individual's mental health, social wellbeing and risk of offending (What works)*

I would expect that all three groups would agree that forensic groups are Important

Patients

1.... Support groups are important because; You get to meet other people

People to listen to your problems; Giving advice to you; Help with getting back into the community after being away for a while

2.... Found group very good, you know like the ones in probation .For me I have a drink and drug problem lately and I think groups would be helpful for this problem

3.... Gets me out of the house; I learn new things e.g. how to cope better, learn new skills, helps with problem solving etc., The whole course has been very good

4.... I don't see the benefit of these groups

5.... There can be an outlet for you to talk about how you feel. They are something very important.

6.... I learned a good bit from the group. I got to meet new people

Families

1....I think it seems to be good for them... It highlights their offences gives patient background to things.

2.... Yes they were helpful at the time...Although now he is doing nothing...

But yes very good at the time.

3.... Definitely good for certain people.... I have tried before and it **doesn't work for me**. I have my own good family support and I always turn to them.

4.... They are very important. **Our family could have done with more**. One time we went to a focus group and met other people with similar situations, these groups helped because you got to hear other people's stories, and that **helps you to understand more**.

Professionals

1 ...the patient needs to believe that they are going to get something out of the group, that there will be some value, real value ...patient must believe that there is going to be something in it for them ...it's going to take **motivation** ...let them see what benefits there would be in the group.

2 ...the **group work is therapeutic**... understanding through the group process about offending behaviour...**helps see the consequences of offending behaviour** and learn about strategies and ways of managing it. ... help people how to manage, everyday living skills, coping strategies, in that setting with an experienced practitioner, they can identify with other people in the group...they realise there are other people out there and they don't feel alone and often they can help each other....this is a **very positive service**

3.. I think on the most basic level it's the social aspect, I also believe in the possible role model effect off group work and a lot of cognitive behavioural programs are a good impact because **they achieve change from people learning from the group of members, (people can change through therapeutic group work)** so there's a lot of positive modelling behaviour goes on in group work....the size and style of the group might not be suitable for everybody so you have to also tailor the person to the group....**a lot of our programs here are based on group work and I have seen the difference in how people change and behave they feel more in control of their situation**.

4...They work if the patient is willing. I believe all **patients can change** but the key is they **need to be motivated to change**. I feel group work

can help them identify their problems, take recognition of them because often some people don't even realise that they are doing something wrong

Treatment Intervention Item	Key Issue	Question
<i>Purposeful life helps prevent reoffending</i>	In study two all three groups agreed that having ' <i>purpose to one's life</i> ' was important in preventing a re-offence.	How is a purposeful and fulfilled life important?
Key Responses to Question All three groups agreed that having positive social outlets was important in preventing a re-offence. (see also Psychological Well Being) <i>'Meeting people has improved my mental health'</i> (Patient). One family view concurs ' <i>Something for him to do every day, something constructive</i> ' Professionals highlighted ' <i>good thinking skills are positive, helping them deal with everyday situations for example comorbid substance misuse things like that can increase the risk of offending behaviour</i> '		

Extracts of participant responses *Having a purposeful and fulfilled life plays an important role in preventing a person from re-offending ('Good Lives' model)*

I would expect that all three groups would agree that having a purpose and fulfilled life is important.

(NB – This also relates to Psychological wellbeing responses)

Patients

3....Meeting people is really important; For example meeting your friends, getting out of the house, this can give you a new lease of life;

Meeting people has improved my mental health as when I stay in the house all the time I see no one and don't eat properly
Families 2... Something for him to do every day, something constructive, that would make him feel good about himself and give him something to look forward to.
Professionals 2.....good thinking skills are positive, helping them deal with everyday situations for example comorbid substance misuse things like that can increase the risk of offending behaviour

Treatment Intervention Item	Key Issue	Question
<i>The 'troubles' in NI has a negative impact on patient rehabilitation</i>	In study two all three groups generally responded in a neutral way to this statement. However, the professional group were slightly more likely to agree.	The general response suggests that all groups have no hard opinion on whether the troubles have had a negative impact on patient rehabilitation. Why?
Key Responses to Question The results for this question reflect a mixed viewpoint. Patients chose to either not respond 'don't know' or comment that the troubles have not had a negative impact on their treatment. Family members, however, were more forthcoming in their responses. For example, ' <i>He was heavily influenced by them (paramilitaries) when he was younger</i> '. ' <i>He was really intrigued by the troubles</i> '. ' <i>Since the troubles have got better, he doesn't</i>		

even read a newspaper or talk about them (paramilitaries)'. It is interesting that the professional group agreed that the troubles in NI have had a negative impact on rehabilitation. For example, 'One is that the troubles in Northern Ireland haven't entirely gone away and people still believe that there is a risk out there for them'. 'The ability of people to open up and be truthful about it, their fears may still be restricted due to the fact that there is still a perceived threat from particularly paramilitaries or organisations like that'. This is exhibited in terms of substance misuse due to post traumatic symptoms and high rates of anxiety and depression, particularly for those people living in fear of paramilitary groups.

Extracts of participant responses *The 'troubles' in NI has a negative impact on patient rehabilitation*

Again this is an unknown quantity. I would be interested in exploring any difference between the three groups

Patients

- 1..... Yes, the troubles have affected people, but in a good way too there are re-assessment groups available, there to help people through
- 2.... Don't know
- 3.... No comment
- 4.... No negative impact
- 5....No
- 6....No, I don't think so

Families

- 1.....Possibly at a time they did, but not so much now.
- 2.... Yes I feel the troubles have had an impact...Especially for B, he is very vulnerable; people take advantage of him....
- 3.... Unless you're an actual by product of the troubles. Then no not really.
Maybe if we were in different areas
- 4.... For us the troubles have ruined A....heavily influenced by them when he was younger... was really intrigued by the troubles...always wanting to

know what was the latest thing happening....Since the troubles have got better, he doesn't even read a newspaper or talk about them now.

Professionals

1- ...as a statement it's probably true- multiple reasons. One is that the troubles in Northern Ireland haven't entirely gone away and people still believe that there is a risk out there for them so that the ability of people to open up and be truthful about that ever it is there fears may be can still be restricted due to the fact that they are still is a perceived threat from particularly paramilitaries or organisations like that.

2 ...there's a lot of post traumatic anxiety around and in Northern Ireland we are still dealing with the legacy of that....its patients who this trauma has impacted on them when they were younger....there is a cultural fear of paramilitary organisations and that does impact on the work... we have got very high rates anti-depressant prescriptions, and we have one of the highest rates of tranquiliser prescriptions, and we have lots of dependency on these medications...high rates of substance misuse, which would go hand in hand with the post traumatic symptoms....some of the patients here that are victims have then become perpetrators.... the troubles does certainly create an additional work load which isn't adequately funded....legacy of a dependence on tranquilisers and anti-depressants to deal with these problems before we can look at psychological therapies

3....if you look at it from a sociological perspective everyone has been affected by the situation....I have dealt with people who have experienced post-traumatic stress disorder 10 – 15 years later....there is a legacy..

4.... To some extent I do...I feel now that there is a new generation, but yes in the past you could see that the political side of things often shaped and moulded some people...there are still pockets of this in our society. But I feel now that there is a new drug culture developing, people have moved on from the troubles. Before I think paramilitaries often kept offending behaviour low through their own means and now there isn't the same control. So we see a culture where people will do anything to get ££ for drugs, anyway to finance the habit.

Treatment Intervention Item	Key Issue	Question
<i>Support group for families</i>	In study two there was no significant difference between groups in this area. However, all three groups agreed support for families of forensic patients is important.	What kind of support group for families should be established?
Key Responses to Question Responses indicated that generally speaking families are viewed as a <i>'protective factor'</i> and help <i>'minimise risk'</i> for mentally-disordered offenders. A support group was viewed as something that could be <i>'educational'</i> , providing information on mental health and offending behaviour and an opportunity to <i>'talk to people in a similar situation'</i> . Professionals also support groups as a way of helping families cope with the stigma attached to mental health and offending behaviour.		
<i>Equal focus on offending, mental health and life skills in treatment</i>	In study two all three groups agreed that in treatment equal focus should be placed on offending, mental health and life skills.	What should treatment look like regarding offending needs, mental health and life skills?
Key Responses to Question All groups emphasised in particular the importance of developing a healthy lifestyle. The negatives of hospital were highlighted such as becoming too dependent and <i>'losing the skills you had before...hospital is not like the real world'</i> (Family).		

Extracts of participant responses *A support group for families of patients with forensic mental health needs would be beneficial ('What Works' model)*

I would expect all three groups to view this as important, however would probably be of more significance for the family group.

Patients

1.... Would be **good for them** to have people to talk to and give advice, you know if the offender was maybe getting out of hand again.

2.... Really don't know

3.... Yes this would **help families learn how to cope with the person who is unwell**; Wouldn't like to put too much responsibility on the family member. It's my responsibility to deal with my problems

4.... Would be beneficial for B Not for the children afraid it would bring my illness to the front of their mind, scared they would know how ill I was sometimes.

5.... Yes like something for my (partner)....**could talk to people in the same situation**. A focus group. I feel the family needs support too.

6.... Yes there should be support

Families

1....They would be good for the family. For example we didn't know the course content for the courses he was attending...We could have been better informed...**Meeting and talking to other people in the same situation would be good**, means you would not feel as isolated and alone perhaps knowing there are other people out there going through the same thing.

2.... A group to talk to people who are going through the same thing would be helpful...For me I just turn to my friends...You know someone to talk to would really help us.

3....As much or as little as they need. In the past sometimes people came in all guns blazing, and it's not needed. I also think every single person should have a social worker in place. Simple things like knowing what benefits to claim, like I would love to be able to go out and work but looking after A comes first...in hospital and his money has been stopped and we have really struggled financially....**Only for family support we wouldn't have been able to survive at times like that**

4.... Well we already attend a support group that really helps...needs more courses, something more constructive that he can stick at...needs to be consistent... a lot of the groups and courses only run for a certain time period. One time we went to a focus group and met other people with similar situations.....that helps you to understand more.

Professionals

1 ...beneficial because it keeps them very much in the loop...better support for the client if the family are aware of the issues that are there for the patient...act as a support extra therapeutic input for themhelp minimise the overall risk.

2..I know whenever I have patients here with forensic needs you would often make time to speak to a relative because there is a lot of anxiety around relatives...often the family can feel very stigmatised within their own community and if you're trying to be a carer for the person who is the offender it's an additional stress and burden...if you're the carer for someone with forensic mental health needs a support group can be very effective... if you got patients involved and setting up a support group for their relatives

3... a need for families just to understand a bit about mental health generally,they have seen lots of behaviours....very difficult...the first thing you could do would be educational work, and I think the second thing is informing families about services and how services work and how to access them... they can decide themselves about how much support they need after that and it varies from family to family

4... Anything for families is beneficial. Some families have no clue how to deal with the individual and their problems or be it their illness. I found over time that even if they individual is unwilling to change, that often the family can change in terms of how they cope and deal with things.

Treatment Intervention Item	Key Issue	Question

<i>Stepped down facility between secure environment and community living</i>	In study two this was an area in which the professionals agreed more than the other two groups with the usefulness of a stepped down approach.	What should a stepped down facility look like?
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Key Responses to Question

Interview responses highlighted the importance and need for a step down approach in Northern Ireland. Professionals had the most to say on this subject; *'big step to go from security to the community and get back to day to day functioning'*, *'being exposed to the world after being in such a secure environment is scary'*. Suggestions for what a stepped down approach would look like included: *'supported living environment'* where there would be *'an opportunity to engage in therapeutic work'*. In addition, it should be *'well supported and managed'* with *'continuity of care in terms of key worker for the first three months back in the community'*. Patient and family group also supported the idea of a step down approach. *'I think everyone should go through this approach before going out into the community'* (patient) and *'gets you used to being out of prison, but curfews are in place to keep you on the right track'*.

Extracts of participant responses *There should be a 'stepped down' facility between secure environment and community living for forensic patients ('What Works' model)*

I would only expect the professional group to be interested in this.

Patients

1.... I think they should have; Rest Homes; Somewhere to go for a few months or a year before they move back into the community...**I think everybody should go through this approach before going out into the community....they would be very helpful**

2.... A step down should be well planned....my experience was far too rushed, 4 days before Christmas I was discharged...I needed to find a house, and I didn't have enough time to do all these things

3.... I came straight out into the community from X and coped ok. However a halfway house would be good, some people might feel very unwell and it might be a good thing

4.... Step down would be a good idea. Depends on the person

5....From a prison to a hostel. It gets you used to being out of prison, but the curfews etc. are in place to keep you on the right track. Support from mental health services.

6.... Places like the X centre. And more courses to do

Families

1.....Sheltered accommodation perhaps...A move down from hospital
....Support for the patient before they come home

2.... Definitely more support needed... find it frustrating, B seems to be in and out of hospital and there seems to be nothing in between....Even when he's been in hospital after attempting to take his life we go from all being very worried and running to the hospital to see him to all of a sudden he's home. I feel there's not much support available after leaving hospital. And then the next thing is he's back in again.

3....I think the stepped down approach is good.... from hospital he always seems fit to be home...In hospital I noticed they would start over time to give A more freedom,.... to go to the shop, then being allowed out anytime, trying being allowed home to begin with 3-4 days a week. That to me what like a step down

4... A step down approach would be very helpful. A is very dependent on us, and we never get a break. Step down should involve something that gives A support outside of the family.

Professionals

1...people cannot be locked up forever...when people present a risk or they commit a crime.... be a punitive aspect... these people will eventually serve their time...you would hope that a step down unit say to moderate security that a lot of therapeutic work would happen there. But

they also must leave that place...come back to independent type living.

So yes there should be a step down but it should be well managed and well supervised.

2...Yes it's been an issue with patients who are discharged straight from X clinic or from a local medium secure unit that go straight into the community....a big step to go from that level from of security and you know to go to live back in the community and have the responsibilities for those activities (daily living, getting benefits sorted, your housing sorted) just getting back to that day to day functioning especially if you've done something particularly with regards a violent offence or something that was in the media it's going to be very difficult to being back in that community... so it's a big jump to go from medium secure to living in say a rented house somewhere...something as a step down say like a group home where there is additional support would be good as part of a comprehensive service...

3.... A step down needs to involve gradual moves home, a day here a day there a phased return almost.....people gradually testing things out over a day or two....important to have consistency with the workers involved in moving a patient out from hospital into the community, they can then judge how the person has coped with the move and can look out for different behaviours etc.... so continuity of care of the key worker for at least those first 3 months back in the community and then perhaps things are stable consider a transfer or even joint work.

4... Absolutely...Being exposed to the world after being in such a secure environment is a scary thought for some people. I think in the process the treatment needs to be continuous, without this then people have a greater chance of re-offending. A supported living environment would be best.

Table 3: Treatment Responsivity

Treatment Responsivity Item	Key Issue	Question
<i>Family plays an important role in motivating a person to engage in treatment</i>	In study two there was no overall statistically significant difference between groups.	The family plays an important role in motivating and encouraging a person to engage in treatment, how can this role be enhanced?
<p>Key Responses to Question</p> <p>The professional group had the most to say on this subject. Professionals felt that families could be an excellent motivator in helping a patient adopt a healthy lifestyle, daily living skills and <i>‘look out for relapse triggers’</i>. More support networks for families were suggested at a much earlier stage than is currently in place, for example, when a person first gets referred to mental health services. The family group felt there was a limit to what they could do <i>‘you can only do so much but you always feel you could do more’</i>. They also stressed the importance of the patient working with the treatment <i>‘important the person sees the treatment as a friend and not the enemy’</i>. The patient group strongly supported the role of the family in their treatment; <i>‘they need to understand about illness (offending); ‘More education for families needed’ and ‘group work with families to help them understand and support each other’</i>.</p>		

Extracts of participant responses *The forensic patient’s family plays an important role in motivating and encouraging a person to engage in treatment (‘Risk-Need-Responsivity’ model)*

I would expect all three groups to agree with this but probably more so the family members.

Patients

- 1.... For me I feel the family should always be at meetings...to understand about the illness of the person, best way for that to happen is if they attend meetings (doctor meetings, clinical meetings). Also having someone who knows about the illness, so the family can talk to them, they could provide the family with information- useful numbers to phone in case things got out of hand, no matter what time day or night.
- 2..... More education for families needed....they don't always understand the nature of these problems. As long as patients consent, always keep families well informed.
- 3.... Not sure
- 5..... It does play an important role. Could be enhanced by more group work with families to help them understand and support each other. Acceptance from the family is important...I was lucky because (partner) stood by me.
- 6.... Family are there if I need someone to talk to. My (relative) encourages me to take my tablets. I don't think any more help is needed

Families

- 1.....We do try to encourage....Although sometimes it's the case if they make their mind up nothing is going to change it....Sometimes you can only do so much, but you always feel you could do more
- 2..... I don't think the family really understand that he has a mental health problem...hey think it's only a drink problem but I know it's not...Maybe things would be better if they understood more.
- 3.... Yes important if the person sees the treatment as a friend and not an enemy. There is privacy issues, when A is ill I think he can see the treatment as the enemy but when he is well he responds better...
- 4.... We could do more probably; take him places everyday if only we knew which places to take him....a gym but outpatients aren't allowed to attend it, something like that would be great we could drop him off for an

hour to two and it would be good for him and us.. Overall I think there needs to be more services

Professionals

1...They do but it's not always the case... you can have families that have broken down completely and are dysfunctional to start with....they may be supportive if they are involved in the patients care and involved in knowing what the patient is going through. It may also be that they can still be quite antagonistic; some of the initial offences may have actually been committed against family members so it can be very difficult to repair some of that damage...

2...Yes you have to have the family involved and engaged with them because they are going to help with compliance....They are also going to help motivate with a healthy lifestyle...engagement with family is very important for - Help with medication compliance; Help with daily living skills;

Also to look out for relapse triggers which they can liaise with key worker

3....Often I find within a family they are very frustrated with the person and the problems...that have been going on for years.... there needs to be something before people get to forensics ...have support groups and that that's offered at each point of contact...

4... More support networks are needed. Family interventions perhaps. Family dynamics are very important in any case, sometimes it's very helpful to show a family how to help an individual through recovery.

Treatment Responsivity Item	Key Issue	Question
<i>Professionals play an important role in motivating a person to</i>	In study two the three groups all agreed with this statement.	The professional plays an important role in motivating and encouraging a person to engage in

<i>engage in treatment</i>		treatment, how can this role be enhanced?
Key Responses to Question Professionals felt that motivation was central and key for treatment gains to be made ' <i>central to getting people engaged and gain maximum benefit from intervention</i> '. Families would like ' <i>more support</i> ' from professionals and felt they need to know their patients better ' <i>How can they motivate someone if they don't know him well?</i> ' Patients would like more input into their treatment. They valued the role of therapeutic groups that professionals deliver ' <i>gives me something to look forward to every week</i> '.		

Extracts of participant responses <i>Professionals have an important role to play in motivating a person to engage in treatment ('Risk-Need-Responsivity' model)</i> I would expect all three groups to agree with this.
Patients 1..... Not for me, but maybe for other people....Before I left hospital I made sure I had everything I needed, you know (numbers to call if I needed help, meetings I could go to). 2.... Very important.....I think they should not always dictate to a patient, maybe work with them more. Discussions needed around treatment, you need patients input. 3.... The Good Thinking Skills course has been great and has given me something to look forward to every week. Don't think anything needs to be upgraded 4.... They do play an important role 5.... Yes they play an important role...really sure what else they could do. I have had good support. 6.... I don't think they could do anymore
Families

<p>1...In our case, we had a lot of help at the start, now it has all stopped. I think it's hard for A to cope with this...Now we are only left with the social worker in (name) House</p> <p>2..... More support for families would be good...Now the help has stopped for us...Sometimes I feel like he is just left on his own to cope with everything.</p> <p>3.... No not really. Except for the key worker. Doctor only sees you for 10-15 minutes. Professionals need to be more on the ground, maybe have more time to observe and see. I think they rely a lot on what the notes say. How can they motivate someone if they don't know him well? For example our family know even to look at A if he is unwell.</p> <p>4.... Everybody has been very good</p>
<p>Professionals</p> <p>1....The motivation of patients is a central role and without that you're not going to get people engaged fully and they won't gain the maximum benefit from an intervention you're going to have with them. So motivation is absolutely central and key.</p>

Table 4: Collaboration and Support

Collaboration and Support Item	Key Issue	Question
<i>Transition services between the hospital and community need to be improved upon</i>	In study two the family and professionals agreed with this statement. There was a statistically significant difference between the patient and family and patient and professional groups in that the patient group were more likely to disagree with the statement	How can transition services between the hospital and community be improved upon?

	than the family and professional groups.	
<p>Key Responses to Question</p> <p>Both the family and patient groups felt they needed more support in the context of moving from hospital to community living. For example, <i>‘there is a gap between hospital and community’</i> (family), <i>‘a phased approach (to community living) works better’</i> (patient). The family also stressed the importance of having help with practical day to day things such as social activities and outlets for the patient - <i>‘X diagnosis is for life and we feel treatment should be on going’</i>. The professional group stressed the importance of consistency between services - <i>‘a lot of people don’t seem to be seen by forensics until something bad has happened, you feel they should have been involved with forensics years ago, before something bad happened’</i>.</p>		

<p>Extracts of participant responses <i>Transition services between the hospital and the community for forensic patients need to be improved upon (‘What Works’ model)</i></p> <p>I would expect the professionals to agree with this statement however would predict that patient and family members would not be aware of problems in this area.</p>
<p>Patients</p> <p>1.... I think the key worker should be calling 2-3 times a week if someone is moving back out into the community. A meeting once a month with the doctor would help</p> <p>2....There are not enough services...they have been trying to find services for me...Often all they tell me is that services are ‘not appropriate’ because of my offences....they should arrange services better to suit certain offences</p> <p>3.... Was ok for me. I didn’t go out straight away though it was a phased approach.... works better e.g. one night a week then weekend before moving out full time.</p>

4.... Generally they are alright

5..... I think you can be very vulnerable at these times so you need something that is very supportive

6.... I don't know

Families

1....Better communication....Forward planning with the family....In our case this did not happen...A. was discharged....without any pre planning, the judge made the ruling that afternoon and then A was home. It was hard for us, I had to ring work and just say I would be off work for a while because he could not be left alone....a huge responsibility put on us

2..... I think there is something missing.....there is a gap between hospital and the community....B seems to be in and out of hospital and never really ever seems to change and now I feel at the minute he's doing nothing constructive with his time.

3.... Would be nice sometimes to even get a phone call or a call to see how A has settled at home. Social worker would again be helpful. Being better informed. More support from the professionals. Help with practical day to day things.

4... After hospital, he was sent to A (hospital) that was great for him, but then he was discharged after 6-8 weeks. We just felt that wasn't long enough, but I suppose it's like everything you only ever get a specific time frame in these places....X diagnosis is for life and we feel treatment should be on going.

Professionals

1....we are at a very embryotic stage of development in these services....but I think we have made good strides from the justice system itself where patients are picked up earlier and seen by mental health services and where that happens you have a much greater link to the hospital services, and from hospital services then you now have forensic service in the community and that's certainly moving in the right direction....

2.. I look after primarily outpatients so I don't see a lot if the inpatients but I know there is a comprehensive discharge meeting on the ward.

3...I think that the referral process to Forensics is not particularly clear...**a lot of people often don't seem to be seen by forensics until something really bad has happened and you feel they should have been involved with forensics years ago before things got bad**...I feel that patients who are maybe viewed as problematic and difficult say perhaps on the ward get quicker contact with forensics...**what criteria people are making when they judge forensics because it doesn't seem to be consistent criteria.**

4...There is very little support at the minute. I feel there are lots of primary mental health care workers, but how many forensic nurses are out there?

More support is definitely needed. Looking at different care pathways and assessment tools. Perhaps training could be provided to learn how to deal with forensic needs

Collaboration and Support Item	Key Issue	Question
<i>The forensic team need to increase awareness of the service and what they do</i>	In study two professionals agreed with this statement however the patient and family groups were neutral. As there was a statistically significant difference between patient and professional groups this was further explored through interview.	How and in what way can the forensic team increase awareness of their service?
Key Responses to Question Professionals felt that more awareness of who the forensic team is and what they do was required. Both the patient and family groups concurred with this view - <i>'more awareness that the service is available, we didn't know about it until the offence happened'</i> (family) and <i>'education about</i>		

the criminal justice system e.g. the difference between a forensic psychiatric nurse and a community psychiatric nurse’.

Extracts of participant responses *The forensic team need to increase awareness of the service and what they do*

I would expect the professionals to agree with this statement however would predict that patient and family members would not be aware of problems in this area.

Patients

1.... I think the system is ok as it is

2.... I'm not sure if they really need too. Bad press means sometimes too much focus on mental illness and offences. Forensics is a service you don't really need to know about unless you have been referred to it. Maybe education about the criminal Justice system, in A case the Judge didn't know difference between forensic psychiatric nurse (FPN) and a community psychiatric nurse (CPN)

5..... No idea all I know was that I was referred by my psychiatrist.

Families

1...I think more awareness that the service is available, we didn't even know about it until the offence had happened.

3....No

Professionals

2... I've got to know what's available throughout the correspondence after assessment about the different groups that are being offered like the 'good thinking skills' and you hear more about what's available... there's very good communication.... One way of informing medical staff or primary mental health care services would be access to the senior clinical staff meeting; the other way would be to have a case conference presented by the forensic team...would be a good way of updating everybody about what is available

4... I think there needs to be more communication on both sides....if I wanted to contact forensic services I would have to go away and look up who worked in the department because it's not readily known.

Collaboration and Support Item	Key Issue	Question
<i>Relationships between the forensic team and other teams could be improved upon</i>	In study two professionals and family agreed with this statement, however, the patient group were neutral. As there was a statistically significant difference between patient and family and patient and professional groups this was further explored through interview.	What steps could be taken to improve relationships between services?
Key Responses to Question All three groups agreed that more joined up working is required - ' <i>More support between services</i> ' (patient); ' <i>needs to be greater access and joined up working</i> ' (professional) and ' <i>seems to be a lack of communication...they don't work well together</i> ' (family).		

Extracts of participant responses *Relationships between the forensic team and other teams could be improved upon*

I would expect the professionals to agree with this statement, however it would be interesting to determine whether patient or family group have picked up on any issues in the working relationships between services

Patients

- 1.... More support between the services
- 2.... They seem to already work well together
- 3....Would have liked more access to the key worker in the community when I was in secure hospital. To talk things through before moving into

the community. I was unsure of what I needed to do and prepare for community living
<p>Families</p> <p>4.... It's been our view that often the forensic team and the CPN's don't work well together. Always seems to be a lack of communication. We found that each service passed the blame to another service, one we say 'oh that team isn't doing enough' and vice versa. Would be better for everybody if they worked together more.</p>
<p>Professionals</p> <p>1...I think that's also true and I know that there have been some discussions at management level to see how we can improve on that situation. I think we are going to see more forensic attendance at both primary care team meetings and support and recovery team meetings. And that way you're going to have greater access...the service will joined up working - be more joined together.</p> <p>3.... Absolutely....I think the forensic team itself is not very publically known in fact I would even go as far as to say they are beneath the radar to some people....you don't get the impression that they are an integrated part of the mental health services...the whole process of the interface of the community mental health broadly it's not clear to me</p>

Table 5: Family Involvement

Family Involvement Item	Key Issue	Question
<i>The family plays a crucial role in the management of a forensic patient</i>	In study two all three groups agreed strongly with this statement.	Why is the role of the family so crucial? How could this be improved?
Key Responses to Question		

The patient and family groups had the most to say on this subject. The patients appeared to have the strongest views and forcefully advocated the role of the family in the risk management and treatment plan. For example; *‘they know the person best’ and ‘they need to know everything about the illness so that when something goes wrong they know what steps to take’*. There was also a desire for acceptance from the perspective of the patient group; *‘important they see past what the person has done and learn to except you’*.

Extracts of participant responses *The family plays a crucial role in the management of a forensic patient (‘What Works’ model)*

I would expect all three groups to see this as important particularly the family group.

Patients

- 1.... The family really need to know everything about the illness, and then they know what to do when something goes wrong, or what steps to take -to look out for. Support from the family is good.
- 2... Better education
- 3.... Family notices the change in the patient. They know the person the best and would see the difference in their mental health
- 5.... It crucial they give you moral support and love...helps to stop you from feeling like you’ve been abandoned. Important that they can see past what you have done and learn to accept you.
- 6.... If I need someone to talk to

Families

- 4.... Because sometimes it’s only you they have

Professionals

Professionals agree as indicated in treatment responsivity item (table 3) and next response

Family Involvement Item	Key Issue	Question
<i>More support should be offered to the family of patients with forensic needs</i>	In study two all three groups agreed strongly with this statement.	What type of additional support could be offered?
Key Responses to Question <p>All three groups had much to say on this subject. The professional group felt that a support network would be useful to; <i>'help educate about how to manage different behaviours or even how to manage the legal and court system'</i>. The family often felt <i>'lost'</i> due to their perceived lack of support. The patient group was of the opinion that as the family <i>'know the patient best'</i> then there should be <i>'more groups and courses'</i> for them and they <i>'should be involved more'</i> in the patient's care.</p>		

Extracts of participant responses <i>More support should be offered to the family of patients with forensic needs</i> <p>I would expect all three groups to see this as important, particularly the Family group.</p>
Patients <p>1.... More groups and courses....Family should be involved more 2.... Better suitable services for specific offences...some services that are offered are often not suitable for my age group. Like Mind ways has just had a 40% budget cut, opening hours has now been reduced to 10 am – 2.30 pm, this affects me. 3.... To relate to them what is happening to the patient. Ask the family what they need. They know the person best and could communicate any change to professionals 4.... No additional support</p>

5.... **More support for the family**. Would be good to get (partner) more involved, maybe this would give a better understanding of where I was then and where I am now.

Families

1.....Maybe to see somebody every now and then just to be able to talk about what has happened....Perhaps a family focus group?

2.... **We all feel lost at times**....Feels like nobody talks to us about things.

With us we don't talk about it until something new happens...**For me it feels like we are waiting in a ticking time bomb.**

3... Social Worker

4.... Any additional support would be welcome. A really enjoyed the X but Z had too many old people there and they were all sleeping need people A's age.

Professionals

1....there has been a scarcity of it to date.... I think the services need to be equal but we do need to be striving towards developing greater supports for families and carers right across our services.

2.... a lot of the support for the adult mental health population is through the voluntary sector, various carers groups for families....our community mental health team get involved in supporting the voluntary sector and go out and do talks and link in with the carers groups. This should equally apply to patients with forensic needs and it might be a better outreach if there was a specific group for carers of patients with forensic needs in the voluntary sector....any family...had a young adult son in and out court, offending behaviour; another support network would be very useful to have...carers group....**to help educate you about how to manage different behaviours or even how to manage the legal system and court system**, what probation is all about, some more education about what's available from the forensic services that would be very helpful.

3... Yes I think so because with forensics there's an assumption that there is a greater level of need and therefore there should be a greater

level of support. Often sometimes with clients the only reason they are able to be out in the community at all is because of that family support.

4... Very often the family take on all the patients concerns etc. Often it's very helpful to be able to sign post them to services that are available because often they don't have any idea.

Table 6: Psychological Well Being

Psychological Well Being Item	Key Issue	Question
<i>Social outlets and relationships help promote an offence free life</i>	In study two all three groups agreed with this statement and there was a statistically significant difference between the patient and professional groups in that the patient group were more likely to agree with the statement than the other two groups.	What type of social outlets and relationships help promote an offence free life?
Key Responses to Question All three groups agreed in interview that this was important. Differences between groups were in terms of how social outlets and relationships promote an offence free life. The patient group on the whole saw social outlets and relationships as a protective factor; <i>'mix with the right people...having a girlfriend would help me'</i> and <i>'stay away from people you know you are going to get in trouble with'</i> . The family group focused on the types of activities that would be of help and advocated that they should be responsive to the person's needs; <i>'something for him to do every day that would make him feel good about himself and give him something to look forward to'</i> ; <i>'better social activities responsive to his needs'</i> and <i>'a befriender scheme'</i> . The importance of positive, pro-social friendships was emphasised by all three groups. The professional group		

also emphasised the importance of services that are responsive to a person's needs; *'needs to be practical and therapeutic, tailored to individual needs'* and acknowledge the difficulty in identifying such services for people with offending behaviour *It's difficult because the stigma of your offending behaviour especially patients with a certain risk history to get involved in these organisations, often they involve police checks, etc., ...Stable relationships are very important, stable friends etc. sometimes this can be very difficult if the person is socially isolated.'* Fundamentally, they also felt that the person should be *'interested'* in the service that is offered and that it should be accessible in terms of where it is offered location wise, particularly for people living in the more rural areas.

Extracts of participant responses *Social outlets and relationships help promote an offence free life ('Good Lives', 'What Works' model and 'Risk-Need-Responsivity')*

I would expect all three groups to agree with this item but more so the patient and family groups.

Patients

1.... Keep yourself busy...Plan things day by day...That was give us a jump towards a clean society

2.... For me it's about staying away from people that you know you're going to get in trouble with. Some of my friends are not good to be around.

...hard to avoid all these friends, because they all live close by. So places that I'm not going to be around these people would be good.

3.... Go out regularly – opportunity to meet new people, having a girlfriend would help me, start a relationship; Don't bottle up your feelings; Always mix with people

4.... Don't know

5..... Having a few close friends is good, just having someone to socialise with. I'm lucky I still see my (family) twice a week. Keeping busy helps, walking cycling etc

6..... Well I do swimming....I have a bike.... I like the X centre, its good

Families

1...Better social activities responsive to his needs...Having good friends... A has 2 good friends from primary school...apart from that other people are not that good for him to be around

2.... Something for him to do every day, something constructive, that would make him feel good about himself and give him something to look forward to.

3... Early diagnosis helps. Help and support. Crimes are often the result of the illness you know if people are hearing 'voices'. Perhaps a day hospital

4... For us some kind of befriender scheme that would help....even to take him out to the cinema or go for a coffee....

Professionals

1..Yes they do but they are not always available to people particular in the rural areas...some do exist and where they do probably studies would show that outcomes are better

2...Social networks and stable relationships are very important for anybody with mental health difficulties...particularly for young men, for example getting involved in leisure centres, getting involved in a football club, fit and well projects is a good kick start and a good social outlet....It's difficult because the stigma of your offending behaviour especially patients with a certain risk history to get involved in these organisations, often they involve police checks, etc., ...Stable relationships are very important, stable friends etc. sometimes this can be very difficult if the person is socially isolated. Some of the organisations can provide good social rehabilitation like 'Action Mental Health' for example, but I think there is an onus to pass on a risk history with the patient's permission to the organisation. They are very good at personal development and helping patients and through that with these

various groups patients do form bonds and friendships with the other people who are in similar situations. This is ideal for someone who is social isolated and who may not have a good family network.

3... I think there are a good variety of supports some are quite **practical and therapeutic**. You kind of need **a package that is tailored to the individuals needs and you need the person to be interested in this.**

4.... **Sport programmes, Day/drop in centres,** Tier programs for different levels of support depending on what is required. I have found that probation seem to be very supportive (they provide anger management courses) often we have nowhere to refer patients to so we would find ourselves sending them to probation.

Psychological Well Being Item	Key Issue	Question
<i>Persons and families with a mental illness and forensic history are fearful of their illness</i>	In study two all three groups agreed with this statement. The results highlight a perception that mental illness and offending behaviour carry a stigma.	Persons with a mental illness and forensic history are fearful of their illness, what do you attribute to this and how can it be addressed/managed?
Key Responses to Question Fear was identified by all three groups as a real and significant issue. For the patient group the fear of relapsing and dealing with ' <i>what is in your head</i> ' was prominent. Medication and professional support was identified as important. The family group feared admissions to hospital and the person being ' <i>labelled with a mental illness</i> ' The professional group felt that fear is about ' <i>stigma</i> ', ' <i>the unknown</i> ', ' <i>losing control</i> ', and a lack of insight and confidence that the illness ' <i>is treatable</i> '.		

Extracts of participant responses *Persons and families with a mental illness and forensic history are fearful of their illness*

I would expect the patient and family group to agree more with this statement than the professional group

Patients

1... Yes I do, people are afraid of what they would do, maybe afraid of hurting themselves. With the right medication and right support groups this can be managed.

2.... I'm fearful of missing my medication, for me I miss a dose I can't socialise and be around people, and then this has a bad impact. If I miss medication and then drink or take drugs it's even worse....

3....I came out on the right side however I can see how people could be fearful. I was fearful at the beginning. The help I have got – medication, and engagement with the right professionals has been important

4.... Very much an individual thing. Can be alright or not

5....The fear for me is knowing how low I could get again. And the fear around me harming myself, trying to commit suicide. There is not much more I could do, I know I can ring the out of hours if things get really bad

6.... Sometimes you be scared of what is in your head, and you don't want it to get to you

Families

1...Yes...sometimes he's very anxious... the problem is he doesn't open up a lot.

2....Yes he is...he's very afraid of his illness, doesn't want to be labelled with a mental illness for example he would say to me I don't want to be known as schizophrenic. But really I don't think he comprehends his illness

3...For me, my example would be when A was sent to Ward (Intensive Care Unit)terrifying for me; happened so quick...One minute things were ok then the next thing he was admitted....I definitely was scared

4.... We would notice A fearful, he gets paranoid even about cars coming and going around the house.....

Professionals

1...I don't think that's any different in the world of forensics than it is in adult mental health generally, I think any patient who develops a psychiatric or a mental health disorder a significant part of that presentation is fear and its fear of the unknown, people are always terrified of losing control and that's no different for a forensic patient than it is for the general adult mental health population or indeed the population generally.

2.... I would agree with that because especially when they are unwell... if they have comorbidity and they have substance misuse and that starts again, or they could have a relapse of psychosis or a lapse of depression. The fear of relapsing and their coping strategies and behaviours when they relapse naturally the risk of offending increases.

3.... I think the fear is often around the symptoms of the illness and just the loss of control. Often the illness and the label can be feared. The stigma is still very much there, which I think also comes from professionals because the moment someone says schizophrenia people of my goodness they will be difficult, and ironically in terms of an illness and response to medication its actually very treatable, it's about giving people that information with the knowledge in that area. I think a lot of the fear is ignorance about the illness, about medication and the side effects and I think some of that knowledge would actually help. Then I also think needs to be aimed at professionals, public and the family. The biggest fear I think is that people fear they will lose control, that they will be detained in hospital that they will lose all their rights that they will have no feeling and that if they admit there is a problem they will lose control on what's happening.

4... A lot of times some people have no insight. Often they need direction about how to separate the both. If a mental illness is not treated then that can cause a lot of forensic problems.

Table 7: Public Perception and Awareness

Public Perception and Awareness Item	Key Issue	Question
<i>People who have a mental illness and forensic history are perceived differently by others</i>	In study two all three groups agreed that people with a mental illness are perceived differently by others. What this perception is about and how it can be addressed is important to explore, particularly from the perspective of the patient who in this regard are the subject group.	People who have a mental illness and forensic history are perceived differently by others. Why is this so and what can be done differently about it?
<p>Key Responses to Question</p> <p>The family and Patients had the most to say on this subject. Fear of what others may think in addition to fear; <i>‘of something bad happening again’</i> (family) were key elements within this area. The professional group also highlighted stigma as an on-going issue despite attempts in society to reduce this. The point is made of the relationship between public view and patient view especially around the issue of stigma – <i>‘The stigma attached will always be a problem, and I think the fear comes from the stigma in society. Often they can be afraid of how their lifestyle is going to change.’</i>(Professional). For the patient group the nature of the offending behaviour provoked strong emotions; feeling labelled in a derogatory sense was a key issue. Patient also said that <i>‘my family are afraid I’m going to harm myself’</i>. Education was cited as a possible way of helping the families and public view people with mental health issues and offending behaviour differently.</p>		

Extracts of participant responses *People who have a mental illness and forensic history are perceived differently by others (and fearful of the impact on the family)*

I would expect the family and patient groups to agree strongly with this statement

Patients

1..... Yes **some families would be afraid of the illness**, not knowing what the person could do and not having the right support means they could fall back into it.

2.... **my family are afraid I'm going to harm myself**. They don't manage fear very well I think, sometimes they react in the wrong way when I'm unwell, and they get angry with me which then only makes things worse.

3.... Family would notice me when I was at my worst- they would have been afraid...they are **happier now because of the support I have got from professionals...** I have had that experience with girlfriends. I don't bother any more now because of **fear of rejection** because of my mental illness and past

5..... Often there is a lack of understanding. My X don't understand about my depression at all. I think they are **afraid that I might re-offend**. I suppose **more education and support would help them**

Families

1....I sometimes feel afraid that he is never really going to have much of a life...It's a big responsibly; **I worry all the time about how he will cope.**

4... **the fear will never leave us, especially after that incident, we are always fearful of something happening again.**

Professionals

4.... **The stigma attached will always be a problem, and I think the fear comes from the stigma in society. Often they can be afraid of how their lifestyle is going to change.**

Public Perception and Awareness Item	Key Issue	Question
<i>Public perception and awareness of mental illness and offending behaviour has a negative impact on treatment and recovery</i>	In study two all three groups agreed with this statement.	Public perception and awareness of mental illness and offending behaviour has a negative impact on treatment and recovery. How can this be addressed?
Key Responses to Question This question was asked under the Stigma item.		

Extracts of participant responses <i>Public perception and awareness of mental illness and offending behaviour has a negative impact on treatment and recovery</i> I would expect the family and patient groups to agree strongly with this statement. This question was asked under the Stigma item.
Patients Strongly agree
Families Strongly agree
Professionals Strongly agree

Public Perception and	Key Issue	Question
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Awareness Item		
<i>The public need more education about mental illness and offending</i>	In study two all three groups strongly agreed with this statement.	How can the public be better educated about mental illness and offending behaviour?
Key Responses to Question <p>The professional group had the most to say on this subject. It was suggested that more education is required, perhaps through educating children in schools; <i>‘education programmes in schools to demystify the fear’</i>. It was advocated that <i>‘educate people to more culturally aware about people’s background, the human side of things that we are all the same and we have all go the same needs and to be able to understand each other more’</i>.</p>		

Extracts of participant responses <i>The public need to be educated more on mental illness and offending behaviour (relates to Stigma)</i> <p>I would expect the family and patient groups to agree strongly with this statement – This was responded to by Patients and Family in relation to stigma item</p>
Patients <p>Strongly agree</p>
Families <p>Strongly agree</p>
Professionals <p>1...I think the greater public involvement there is the greater awareness of public there is, I think educational programs in schools from secondary level on I think should be an essential part of any curriculum to make people aware of what mental illnesses are and to demystify the fear.</p>

2.. I think more group work to educate people to more culturally aware about people's background, the human side of things that we are all the same and we have all go the same needs and to be able to understand each other more.

Public Perception and Awareness Item	Key Issue	Question
<i>The religious or cultural divide in Northern Ireland has had a negative impact on recovery and rehabilitation of people with a mental illness</i>	In study two professionals were the only group who agreed with this statement.	The religious or cultural divide in Northern Ireland has had a negative impact on recovery and rehabilitation of people with a mental illness; is this an issue for consideration, and if so, how and why?
Key Responses to Question <p>Whilst all three groups agreed that everyone should be treated equally regardless of their religious or cultural background there was agreement that the religious divide in Northern Ireland does have an impact on treatment and recovery. The professional group had the most to say on this subject, for example; <i>'some people won't go to certain areas for treatment because of the divide'; 'still historical trenches dug in our community'</i> and <i>'people are still wary of the other side'; 'when doing group work sometimes people are reluctant to divulge information about their background'</i> and <i>'people with forensic mental health end up living in areas where there is more polarisation, more integration is needed'</i>. The family groups agreed that the area you live can be problematic; <i>'I need the police</i></p>		

for help and support at times yet the last thing I need where I live as people don't like the police and act up, throwing stones at police cars'. This was somewhat true from the patient perspective; 'if you are looking for housing a bad area may impact negatively on you'. A patient also stated 'some people may refuse a service from someone on the other side of the community'.

Extracts of participant responses *The religious or cultural divide in Northern Ireland has had a negative impact on recovery and rehabilitation of people with a mental illness*

Unknown quantity, want to explore the impact of this on all three groups

Patients

1.... On my account everybody is equal, we should all have the same support

2.... I don't really see the divide as a problem. I suppose for some people they may refuse a service from someone on the other side of the community.

3.... No comment

4.... No nothing whatsoever

5....No

6....It hasn't got any better ...if you are looking for housing..... a bad area may impact negatively on you.

Families

1....Thankfully never affected us....Suppose it depends on the situation, you know if you're looking for housing and where to go.

2.... Yes ...It's hard for me, say for example when I need the police for A if something bad has happened, people in my estate 'act up', throwing stones at police cars....I find this very difficult, I need the police for support and help at times

3.... No not at all...It doesn't matter, mental illness is not discriminate For us even mental illness brings us together.

4.... Yes I do...For me with A it always goes back to the troubles.

Professionals

1...you can argue for and against that question... it can be a very supportive...a lot of people get a lot of comfort from their belief and their faith systems. However, it can also be the source of their difficulties to believe that they are bad or evil people, and religion can actually sometimes reinforce that. The religious divide.....poses its own difficulties and in Northern Ireland there are still historical trenches dug in our community.....people are still very wary of the other side... until I imagine we are talking about decades before we can get through of all that.

2... It has in the past absolutely because I think if you're doing any group work patients be very reluctant to divulge information about their background, but I think that's changing now...some more integration but we still live in a society where there is a lot of polarisation, and people with forensic mental health needs often end up living in those areas where there is polarisation more integration needed....there is poor rented accommodation or poor quality of social housing because that's all they can get, and it can be very difficult to overcome those barriers within certain polarised communities.

3.... I'm not just sure its mental illness but some very fundamental beliefs can have had a big impact on people's lives; I think it's like everything religious a weapon for positive and negative....it's not a bad or a good, it depends how it's used. Some can hide behind religion in the most terrible way to put down other people and be so judgemental. It's positive and negative depending on how it's used.

4....It has, but I think this depends on different areas. Some people just won't go into certain areas for treatment because of the divide. However I do feel this isn't the case as much nowadays.

Public Perception and Awareness Item	Key Issue	Question

<i>There is still stigma attached to mental illness and offending</i>	In study two all three groups agreed with this statement.	What type of stigma is associated most significantly with mental illness and offending behaviour? Ideas for addressing it?
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Key Responses to Question

The patient group felt *'judged'* by others because of their mental illness and offending behaviour. One person said *'you're labelled a monster.... seen as the lowest of the low...once you've got the label you're stuck with it'*. One patient said *'the less the public know the better; stigma can ruin your life for good'*. The family group also agreed that stigma was an on-going issue and *'there will always be stigma'*. There was a sense from the interviews that little could be done to reduce it. The professional group felt that stigma was caused by a lack of knowledge and information about mental illness *'it's to do with fear, people are frightened of mental illness and people who have mental illness, even though we know that it's only a tiny minority of people who hit the headlines with homicidal type behaviours but it's enough to keep that stigma and fear going. We have to work hard towards removing that'* and also a belief that *'people can change and be treated'*.

Extracts of participant responses *There is still stigma attached to mental illness and offending behaviour*

I would expect the family and patient groups to agree strongly with this statement.

Patients

1.... Some **people would judge you for being in hospital**, for me I think to myself at least you done something about it. Ways to help change this would be, more TV adverts, leaflets and more information from your

doctor. Everybody should be taught about mental illness and what can be done to help.

2... Nobody else around me knows, so I have not had the stigma. I'm always being told not to tell people about my offences....to avoid stigma.

I know the staff know but they need to know.

3.... There is not as much stigma as there used to be. If the public knew everything about mental illness they would take you as something else. The less they know the better. Stigma can ruin your life for good.

4....Stigma remains attached. People don't have time for suffers from mental illness....sometimes people don't really have time for you

5.... Yes there is a huge stigma. You're labelled a monster. I think there is a disproportionate view of a 'sex offender'; people's perception is way off.

Once you've got the label, you're stuck with it and then you feel like people don't even want to try and understand. In our society you're seen as the lowest of the low.

Families

1....Yes there is, some people just don't understand about mental illness

2.... People do attach a stigma...Although there should not be a stigma at all. I think it's hidden a lot still, people should talk more about it but they don't....People around my way think it's just drink and drugs for A, people don't realise there's more to it.

3...Definitely there is...People have a mixture of fear. I think sometimes people think 'If I come to close will I get it' Of course there is a stigma. But I think when you live with it, you become very protective

4.... There will always be a stigma attached to mental illness...We have got a great response from the church, police, family and friends. There are times I meet a few people and I know they are awkward around me. When A committed the offence, a lot of people who didn't know us just assumed that it was a combination of drink and drugs related. That was hard to except because they didn't understand that he was ill.

Professionals

1...I absolutely agree yes there is and as much as we have tried to limit that stigma....it's to do with fear people are frightened of mental illness and people who have mental illness, even though we know that it's only a tiny minority of people who hit the headlines with homicidal type behaviours but it's enough to keep that stigma and fear going. We have to work hard towards removing that.

2... Yes people are afraid of people who offend and those who are mentally ill...There's a lot of in this job trying to educate people that they are well and things are under control. People can sometimes be significantly afraid and think always about the worst happening....people are always going to have that fear of relapse and what might happen, and always of particular media coverage of the offence.

3... I suppose its knowledge really. People often just react to the label so a lot of times its finding out people's perceptions of what a mental illness is, and that's it's not a person wondering down a street in a psychotic episode with a knife. There have been a lot of very positive things adverts etc. on TV for example about depression and stress. It's about recognising that pretty much any of us can suffer from a mental illness at some point. I think in terms of offending behaviour it's a mixture again between knowledge and understanding of the person and the situation at that time.

4... Lack of insight and education would be the main thing...Anybody portrayed as 'not normal'. I think often the fears and anxieties come from society...sometimes there is a lack of understanding, people don't recognise that people can change and be treated. We also live in a society which has a 'Blame Culture'.

Table 8: Living Environment

Living Environment Item	Key Issue	Question

<i>People with forensic mental health needs require a living environment and supports that is specific to their needs</i>	In study two all three groups agreed with this statement. The Good Lives Model highlights the importance of addressing non-offending needs in the risk management of offenders. An individual's living environment and resettlement is an important aspect of this and can be a risk factor for re-offending.	What types of accommodation/support is most appropriate for people with forensic mental health needs?
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Key Responses to Question

Professionals were of the opinion that patients where possible should be *'integrated with appropriate supports'* into the community. All three groups agreed that a support network is important; *'twenty fours help if needed'* (patient); *'somewhere there is always help'* (family) and *'a support network that a person can call upon if needed'* (professional). Types of accommodation suggested included *'supported living'* (professional), *'a good area...gives people a good chance'* (patient) and *'a variety of accommodation helps in case risk changes...needs to be tailored to individual needs'* (professional).

Extracts of participant responses *People with forensic mental health needs require a living environment that is specific to their needs ('What Works', 'Risk-Need-Responsivity' model)*

I would expect all three groups to agree with this statement

Patients

1.....Places I think that are good are; Z homes; **Somewhere with 24 hour help if its needed;** A **good area**, therefore **gives people a good chance**

Not just thrown into a rough area, because that can make the person 10 times worse

2... Depends on the individual. For me, generally I cope better living on my own.... I'm on the waiting list for a befriending scheme, but I've been waiting over 3 years now.

3.... Not with me. I have my own home, friends can visit, can do my own thing

4.... **Home is important**. Hospital is good when it is needed

5....depends on the individual. For me, the **hostel was good** because there was someone always there if I needed them and there was rule and regulations in place something you're used to from prison and you need at the beginning.....it's a good start to get you integrated back into normal living.

6.... Somewhere with other people there would be helpful for some people

Families

1....**Somewhere where there is always help if needed** it would be good. Perhaps help with benefits...are entitled to...more help would be good.

2.... **When left alone, can't cope**.... when he has moved out and got own flat, it has become a drinking den somewhere that everyone hangs out. Because he is vulnerable these people take advantage of him, and this usually ends up the flat getting vandalised etc. He did live in a hostel before, but apparently he told me people still brought drink into it and that didn't help him.

3... It depends on how ill you are, for A I think he does better at home...very individual. For us the family unit works better for A.

4... I suppose if they had nobody then **sheltered accommodation** would be good.

Professionals

1... there is an argument here about segregation as to whether you would segregate these people from others. I don't particularly believe in that, I don't think that they certainly will require assistance in some supported **living accommodation**, in **supported work environments**, but I don't think to segregate them into one unit is the answer. Those people who need to be segregated in my view are people who are very unwell and who present with a forensic risk, and they should be treated

possibly in a specialist forensic unit. But when you're talking about people that we are trying to step down then **I don't think segregation is a good idea**... community structure needs to be very well developed..

2... Ideally they want to integrate people with forensic mental health needs into society...they do have specific needs and they do **need support**. Having **a variety of different types of accommodation from supported living, group homes, sheltered accommodation or independent living with some form of monitoring just in case the risk changes**... a variety of accommodation helps, but also accommodation needs to be **tailored to individual needs**....**support network in the background that the person can call upon if they need to.**

3.... I don't think there is a specific type of accommodation, my interpretation of that is that you put them somewhere else. Now there might the odd time be people who are very dangerous that need to be somewhere else for the safety of society, but the vast, majority of people I feel you should be able to integrate with the appropriate supports.

4... Yes for a lot of people definitely. **Environment and support are very important**. There needs to be complete care packages that address all the patient's needs. For me I feel all services need to work as a team.

Living Environment Item	Key Issue	Question
<i>In Northern Ireland there is a negative bias towards locating people with forensic mental health needs in supported living</i>	In study two all three groups were in some degree of agreement with this statement.	This area is addressed through the two previous questions and questions within Public Perception and awareness theme.

Key Responses to Question

This question was not responded to in interview.

Extracts of participant responses *In Northern Ireland there is a negative bias towards locating people with forensic mental health needs in supported living environments*

This question was not responded to in interview.

Patients

This question was not responded to in interview.

Families

This question was not responded to in interview.

Professionals

This question was not responded to in interview.

Table 9: Professional Characteristics

Professional Characteristics Item	Key Issue	Question
<i>Gender influences the working relationship between the patient and professional</i>	In study two the family and patient groups disagreed with this statement, whilst, the professionals were neutral. Although there were no significant differences between group results indicated that the professional group were more likely to agree with this	How and in what way do you think gender may influence the working relationship between patient and professional?

	statement than the patient and family groups.	
Key Responses to Question All three groups felt that gender had no influence on the working relationship between patient and professional.		

Extracts of participant responses <i>Gender influences the working relationship between patient and professional</i> I would expect all three groups to disagree with this statement		
Patients Strongly disagree		
Families Strongly disagree		
Professionals Strongly disagree		

Professional Characteristics Item	Key Issue	Question
<i>Cultural background influences the working relationship between the patient and professional</i>	In study two the family and patient groups agreed with this statement, whilst, the professionals were neutral. Although there were no significant differences between group results indicated that the patient and family groups were more likely to agree with the statement than the professional groups.	How and in what way do you think cultural background may influence the working relationship between patient and professional?

Key Responses to Question

The patient and family groups indicated that in their view cultural background was of no importance to the working relationship between patient and professional. *'It shouldn't matter'* (family), *'everyone should be treated the same'* (patient). The professional group focussed on the nature of the relationship rather than cultural influences, for example; *'the nature of the relationship is central to the overall outcome in treatment'* and *'for professionals it takes a very special person to work with forensic patients...you need to be very aware of your own self and own prejudices'*.

Extracts of participant responses *Cultural background influences the working relationship between patient and professional*

I would expect all three groups to disagree with this statement

Patients

- 1.... No I don't think so
- 2.... It should not really. The professional should always be professional, you would have to be a narrow minded patient for it to affect it.
- 3.... Maybe does influence some people but shouldn't. People might think he/she is of a different religion therefore the person may not like me
- 4.... No influence
- 5.... For me there was no issue at all. Although I have found sometimes there can be a language barrier and that can affect the relationship at times.
- 6.... No they everyone should be treated the same

Families

- 1.....If family are against receiving help, this doesn't help at all
- 2.... It shouldn't matter....
- 4... No that has not been our experience.

Professionals

- 1.... Absolutely yes that's true and I agree with all of that, that the nature of the relationship is central to the overall outcome in treatment, any

interaction you're going to have with any patient and that's no different with your forensic patients or with your adult mental health patients. If you don't having a working relationship and that's one that works then outcomes are not going to be as you had hoped.

2... I think we are all aware of the cultural differences between ourselves and others, the vast majority of professionals don't have any convictions so sometimes they may have difficulty identifying with someone who is going through the legal process....it takes a very special person to work with forensic patients you need to be very aware of your own self and of your own prejudices...The increase of security around hospital, for example security guards in the waiting area....a new cultural trend where we now have professionals at risk of being harmed....to allow patients to be seen that are thought to be quite dangerous...increases the stigma, it's often hard to get a good balance.

3... On a practical level sometimes we do need to use translation services, on another level you need to be aware when I'm working with somebody of peoples cultural groups particularly when someone may have done something that would mean they could be ostracised from their community.you have register it as an additional issue to be aware of, and as long as you aware of this and

4.... It can have an impact. Language can often be a barrier...working with foreign nationals, they can be very suspicious of me as the professional....the relationship needs more work, often they can seem emotionally detached....the need to gain trust, and then this will reduce the fear factor which can be evident when working with people.

Professional Characteristics Item	Key Issue	Question
<i>Personal skills such as empathy, rapport and trust</i>	In study two only the professional group completed this item in the questionnaire.	What are the most important personal qualities?

<i>are as important as technical skills when working with someone who has forensic mental health needs</i>	They strongly agreed with this statement identifying that the personal qualities of professionals working with this population may add to the 'What Works' and 'Treatment Responsivity' literature.	
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Key Responses to Question

Qualities identified as important by the professional group included: trust to reduce fear, non-judgemental *'not imposing your own values'*. The patient and family group agreed that; trust, being open and honest, listening, ability to build rapport, non-judgemental, *'knowing the person inside out'* were all important skills and qualities.

Extracts of participant responses *Personal qualities such as empathy, rapport and trust are as important as technical skills when working with someone with forensic mental health needs ('Risk-Need-Responsivity' model)*

I would expect all to agree with this statement, especially patients

Patients

1.... Someone who knows how to do their job well. Giving good **advice**. Being **honest** with you

3.... They need to **know the 'ins and outs' of the person and how the person needs to be helped – know them inside out**

5..... Someone who can **listen**. Someone you can **trust**, **Openness**. Someone you can build a **rapport** with

Families

2...good support

3...**know A very well**...good relationship...feel you have **back up**

Professionals

2...first thing ...**develop a therapeutic alliance**

3...I think you have to be aware of the importance of culture to somebody... in terms of their values and just acknowledge what they are and then take them into account.....checking that **you're not imposing your values** because they fit better, always be **non-judgemental**.

Table 10: Governance

Governance Item	Key Issue	Question
<i>Organisational constraints impede on the rehabilitation of offenders</i>	In study two professionals agreed most with this statement. There was a statistically significant difference between groups with the professional group more likely to agree with the statement than the patient and family groups.	What are the key constraints? Suggestions for improvement
Key Responses to Question All three groups agreed that there needs to be increased finance and resources for treatment with mentally-disordered offenders. For example; <i>'I would love to be able to develop better social supports, employment opportunities and therapeutic groups but money is the biggest obstacle'</i> (professional); <i>'better staff levels'</i> (family). Essentially, the professional group felt that additional resources and funding was of no benefit if <i>'the patient is not motivated to change'</i> .		

Extracts of participant responses *Organisational constraints (resources, policies) impede on the rehabilitation of offenders ('What Works' model)*

I would expect professionals to strongly agree with this statement.

Patients

- 1..... The patients should have equal treatment, even though there may be cut backs....there **should be some extra money around** especially for patients in hospital to have a chance of a holiday a break....
- 2... There has **always been a lack of funding** in Northern Ireland. Everybody seems to be doing the best with what we have.
- 3.... I do see a bit of this... however also positives like people coming out to see you in your family home and access to a paid taxi for attending a group
- 5..... Maybe in some cases but I have not had any experience of this
- 6.....Don't know

Families

- 1....More finance...**Better staff levels**
- 2.... They shouldn't even make cut backs when it comes to hospital services especially for mental health. They really do affect people. **More help is needed.**
- 3... **Everybody is feeling the cuts now**, apart from that then no
- 4....Finance and Funding

Professionals

- 1... **the key constraints are financial....(we) I would love to be able to develop greater social supports, greater social activity, employment opportunities, therapeutic opportunities but money unfortunately is the greatest obstacle** to our development of these projects in the current economic climate.
- 2...Generally we are **constraint by budgets** and that's the big issue in the health service, especially with the health cuts but it's an area we would probably have to prioritise
- 3.... Key constraints are time and the amount of work that has to be delivered within a certain time frame. **So that means the resources often go to the ones who are either the greatest risk or greatest profile potentially. I work with sex offenders and for instance this work takes a lot of time.** To be fair the organisation I work for does give a good amount of resources and training. I think for me personally there needs to be more cross over between the agencies involved in any case.

4... you need to look at the risk assessment and care management, and what we can offer to them.... you can put policies and resources in place, but the patient is not motivated to change, this can be problematic. Resources however are always controlled by budgets, and at the minute the budgets are stretched to the maximum everybody is feeling it.

Governance Item	Key Issue	Question
<i>Improvements need to be made to forensic services to ensure a whole systems approach so that a 'silo mentality' when working with patients is avoided</i>	In study two professionals and the family groups agreed with this statement however the patient group were neutral. There was a statistically significant difference between the patient and professional group with the patient group less likely to agree with the statement.	What suggestions do you have for improvement?
Key Responses to Question All three groups agreed that increased accessibility to services and more support from services would help ensure a whole systems approach. For example; <i>'we should all work in partnership'; 'knowing how to access the forensic service would help'</i> (professional), <i>'the patient needs to meet the forensic team more to remind him how serious the offence was'</i> (family) and <i>'sometimes it is hard to get in contact with the Department'</i> (patient).		

Extracts of participant responses *Improvements need to be made to forensic services ensure a whole systems approach so that a 'silo mentality' when working with patients is avoided*

I would expect professionals to strongly agree with this statement. It is likely that patients and family groups may not be fully aware of the impact of silo approach on services.

Patients

- 1.... Only problem I have myself is that nobody call out to me anymore, otherwise everything is quite well.
- 2.... Sometimes hard to get in contact with the department. I think they need a secretary all the time especially in case there was an emergency
- 3.....No
- 4.... I can't think of anything else that can be done
- 5..... Nothing apart from offering some sort of support for family members
- 6.....None

Families

- 1....I don't know...They seemed to be very helpful...The nurse was very good at keeping in touch with him and visiting him.
- 2.... More help and support for the patient and the family.
- 4..... X (the patient) needs to meet the forensic team more often to remind him how serious his offence was and that it's never to happen again.

Professionals

- 3...I think the biggest issue is knowledge about the forensic service, knowledge how to access it (the forensic service) for families would help - how to get to it. The forensic service from the outside seems very remote. And if you're not clear as to when somebody might be referred, and who or what makes somebody a forensic case as opposed to another case. I mean at times I have seen people discharged when indeed I have felt that they had such complex needs they should have been referred on. In mental health particularly, the two strikes and you're out I can't get that, that people are discharged because they don't attend
- 4... Needs to be more diverse, so that we should all work in a partnership so that a practitioner doesn't feel burdened and

overwhelmed. Setting up and increasing the service would be helpful. I think there needs to be a team effort to achieve this.

6.7 Discussion

Introduction

The aim of study three was to explore in further detail, using a semi-structured interview approach, the outcomes from the ten themes that emerged from studies one and two. As stated in the introduction to the current study, the results of study two highlighted some areas of significant difference, between the three participant groups. These are:

- The role of a patient's key worker in their risk management and treatment plan. This was endorsed more by the patient and family groups than the professional group;
- Risk assessments and the impact of being risk-averse. This was endorsed more by the professional group;
- Impact of NI culture on treatment and rehabilitation. This was endorsed more by the professional group;
- The benefit of therapeutic groups for forensic patients. Therapeutic groups were endorsed strongly in both the first and second study and therefore warranted further exploration in study three;
- The need for a 'stepped down' approach between secure and community services. There was a significant difference between the three groups in study two with the professional group more likely to agree with the need for a stepped down facility. In study one all three

groups raised this as an important issue and thus this required further exploration in study three;

- The importance of the role of the family in treatment and rehabilitation. This was endorsed by all three groups in study two and also strongly advocated in study one;
- The role of the professional in treatment and rehabilitation. The importance of empathy, therapeutic rapport, and alliance was highlighted in study one and study two. There were significant differences with regard to gender and cultural background of the key worker. The patient and family group were more likely to agree with the statement that cultural background influences the working relationship between patient and professional. However, the professional group were more likely to agree with the statement that gender influences the working relationship between patient and professional;
- The importance of psychological wellbeing emphasising social outlets and relationships. The importance of the 'Good Lives' model and treating a person holistically was endorsed in study one and also endorsed strongly by all three groups in terms of treatment intervention;
- The impact of stigma regarding mental illness and offending behaviour;
- The influence of the living environment for people with mental illness and offending behaviour. All three groups agreed in both study one and two as to the importance of a suitable living environment in rehabilitation and risk management;
- The impact of organisational constraints on rehabilitation. There was a significant difference between groups, with the professional group more

likely to agree that organisational constraints impede on the rehabilitation of offenders.

On the basis of the outcomes from the semi-structured interviews in this study, and taking account of studies one and two and the literature review, each theme is further reviewed in the following discussions:

Risk Management

The importance of the key worker in risk management was recognised as important in both study one and two. When this was further explored through the semi-structured interviews, the three groups were able to identify specific qualities they valued in a key worker. For example: for both the patient and family group, the ability to trust the key worker, in addition to help and support with medication and accessing services, was identified as important. Patients also valued how the key worker enabled them to *'think'* about their offending behaviour with a comment typical of the group being *'prevents me from going off the rails'*. This emphasises the importance of the therapeutic relationship when working with an offender population. Marshall et al. (1999) advocated a number of characteristics essential for treatment effectiveness, such as warmth, trust, respect, and positive reinforcement, factors reiterated in the current study. Offenders clearly value a positive therapeutic relationship and advocate that such a relationship; *'helps me think better'*. The families of offenders also value such a trusting and respectful relationship. It is not dependent on the gender, age, and religion of the key worker.

The patient group also commented on the significance of being seen by the key worker in their own home *'I open up more and talk about my problems'*.

Although this specific service is not available to all patients due to risk issues it does raise the question of what works best with regard to how therapy and support is provided. In the 'What Works' research McGuire (1995, 2001) argues that programme impact is substantially influenced by the manner and setting of delivery. For some patients, having some aspect of their risk management and treatment plan delivered in their home setting may be beneficial, but it may raise fundamental issues, such as potentially blurring the boundaries between therapist and patient. The voices of offenders are often left out of the 'What Works' debate. Studies that have been based upon discussions with known offenders have revealed that 'convicts' are often wary of rehabilitation or treatment efforts within correctional environments (Ward and Maruna, 2007: p 15).

The role of the family in offender rehabilitation is an interesting dynamic that adds to existing research, which frequently focuses on the offender alone. With regard to patient risk assessment and treatment plans deliberated on in this study, the family stressed the importance of being involved, particularly in relation to *'the identification of risk areas'* and *'knowing what steps to take'*.

The results of study two indicated that professionals were less likely to endorse the importance of attention to individual needs in a patient's risk management and treatment plan than the patient and family groups. In the present study the professionals identified record keeping and understanding a person's offending history as important. Professionals also felt that risk assessments could be administratively cumbersome, *'too much paper work'*. The patient group placed a high value on participation in therapeutic groups, having social outlets, and *'someone to talk to'* (i.e. a professional). It appears that for the

patient the therapeutic elements of their risk management are more important than the actual identification of risk and understanding of offending. The difference between patient and professionals with regard to their risk assessment and treatment is reflective of the difference in two psychological theories, the 'Good Lives' (Ward 2000) and 'Risk-Need-Responsivity' (Andrews and Bonta, 1994) models. Patients appear to value the 'Good Lives' way of living, which according to the model takes special account of the individual's interests, skills, abilities, and support networks. The 'Risk-Need-Responsivity' model, whilst it also addresses the needs of offenders, emphasises the importance of risk classification, which in this study professionals view as decisive. This difference between the two groups (patient and professionals) has important implications for how treatment is delivered.

The literature reviewed in Chapter 2 posed an important question with regard to how the 'Good Lives' and 'Risk-Need-Responsivity' models co-locate. How much added value is there in adopting the 'Good Lives' model to existing risk management approaches such as 'Risk-Need-Responsivity'? The findings from this research suggest that there is value to be gained, and that both models can be complementary. All three groups agree about the importance of risk management and attention to criminogenic needs, yet at the same time reflect the importance of addressing other critical aspects of a person's life, such as human relationships, which in their opinion are just as relevant in reducing offending.

Key Points for Consideration

In terms of the risk management of a mentally-disordered offender/patient, areas significant to this and future research include:

- *Role of the family in a patient's risk management:* The findings from this study indicate that a patient's family have a significant role to play in their risk management. All three groups are in agreement with this. This may have implications for how risk assessments are conducted; involving the family in this process may help them feel more included in a patient's risk management plan. Through this approach their understanding of the purpose of risk assessments may increase and they may feel more able to identify 'triggers' for re-offending. Research supports these findings; Visser et al. (2004) in their study of offenders before and after release in Maryland prisons revealed that 63% of prisoners stated their families were a source of support for them. Richards et al. (2009) identified that working with families is important in helping to prevent mental illness relapse, and in a forensic context helps to reduce risk;
- *Role of the key worker in a patient's risk management:* Patients and families clearly value the role of the key worker in a patient's risk management and treatment. Patients see the key worker as someone who helps them avoid a re-offence and value the one-to-one support and guidance they can offer. Marshall et al. (2003) suggest that re-offending is likely to reduce when a 'working alliance' with a professional is developed;

- *The therapeutic alliance between patient, family and key worker:* The study highlighted the importance of the therapeutic alliance for an effective relationship between key worker and patient. A therapeutic alliance between the key worker and the family was also identified as vital. Again this highlights the significance of family involvement in a patient's risk management. Research highlights that a good working relationship between offender and therapist can act as a catalyst for change (Healy, 2010);
- *The importance of social outlets and adopting a 'good life' for a patient's risk management:* All three groups agreed that rehabilitation is not just about a person's offending, but also about ensuring that other aspects of their lives are fulfilling; for example, the accessibility of a positive peer group and the enjoyment of good mental and physical health. Responsivity was emphasised as important in terms of the types of activities a person with offending and mental health needs can engage in. Whilst the family and professional groups could see the importance of the 'Good Lives' model, the patient group felt more strongly about the benefits of it for them, and the professional group placed a greater emphasis on risk management classification. A Ministry of Justice report (2010) highlights that multi-modal, holistic interventions which address a range of problems are more likely to be effective in reducing reoffending;
- *The setting in which treatment is delivered:* This was of most significance to the patient group, who advocated that at times being seen by the key worker in their own home helped them communicate

better. Although this may not always be appropriate for personal and risk reasons, the environment and setting in which therapy, support and guidance is provided is clearly important. 'What Works' research (McGuire, 2001) argues that offence-focussed interventions are more effective when delivered in the community and in a setting that is responsive to the patient/offender's needs. The significance of this dimension to re-offending would be worth exploring.

Treatment Interventions

The therapeutic alliance was identified as being important in the risk management theme, such as in the process of undertaking and implementing risk management plans, and in the relationship between key worker and patient. It would be interesting to determine whether the same conviction is true for treatment interventions and the relationship between the therapist and the patient in groups. It would also be interesting to discover if the perceived benefit of undertaking groups is influenced by the therapeutic alliance between group therapist and patient. Blanchard (2001) examined the experiences of violent young offenders mandated to counselling sessions as a form of rehabilitation. He discovered that participants generally found these counselling sessions to be of more benefit than the previous counselling they had received because of the valued relationship they had developed with the counsellor. Previous sessions had not focussed on the therapeutic relationship between patient and counsellor (Blanchard, 2001: pp 105-106). Although the current samples differ slightly from Blanchard's in terms of smaller sample size, and the current study is focussed on adult offenders, the present

research also highlights the significance of the therapeutic relationship in terms of rehabilitation.

One of the key findings from the present study was the view that therapeutic groups could almost be seen as ‘agents of change’. All three groups displayed this perspective, particularly the professional group: *‘people can change through therapeutic group work’*. This goes beyond the ‘What Works’ and ‘Risk-Need-Responsivity’ theories, which have been criticised for focusing primarily on ‘what to do’ rather than the process of change. Interestingly, some research has criticised the names of therapeutic programmes for offenders in prison such as ‘cognitive behavioural programming’ and ‘reasoning and rehabilitation’ (Latimer, 2001). It is argued that such names highlight the need to change someone who is ‘wrong’, ‘deficient’, or ‘pathological’. Latimer states that the negative connotations associated with many treatment programmes can impact on how they are received or interpreted by offenders and ultimately hinder programme effectiveness, and these names and associated labelling add an unnecessary ‘chill factor’. This is an important consideration when developing and naming treatment interventions. The title or name of a programme, if perceived as negative, underscores the impact of labelling and ‘stigma’, a significant finding in the current study. ‘Stigma’ was seen as a barrier to patients accessing social outlets and thus impacted upon effective treatment rehabilitation. This issue is explored further in the theme ‘Psychological Wellbeing’.

The semi-structured interviews highlighted a *‘sense of loss’* once groups end; consequently, there is a desire for *‘follow up work’*. This finding is widely reported in the psychotherapy literature (Bordin, 1994; Noel, 2012), and

exploring it in more detail may be relevant to groups in the offender rehabilitation field.

Offenders, families, and professionals want more from therapeutic groups than merely addressing the risk factors. There is a common desire to see a fundamental change in the offender. Professionals stressed the value of motivation being in place for people to change. When asked to elaborate on the influence of the Northern Ireland 'Troubles', the professionals asserted that the conflict has produced a legacy of drug abuse from post-traumatic stress in some people, and this has a negative effect on rehabilitation and associated change. Data from 10,000 assessments of offenders' needs in England and Wales (Ministry of Justice, 2010) using the Offender Assessment System (OASys) showed that over half of the offenders had needs related to education, employment, and thinking styles. Additionally, just over half of the offenders in custody were assessed as having a need related to their lifestyle and associates. Drug problems were more common among offenders in custody (39% of those assessed) than in the community (27% of those assessed). Overall, offenders in custody were found to have a greater number of needs. Among adult reception prisoners that took part in the Surveying Prisoner Crime Reduction (SPCR) study conducted in England and Wales, 68% reported that having a job would help them desist from offending, followed by having a place to live (60%). Further research on other defining features in the process of change would be beneficial, especially in the Northern Ireland context.

A key perspective of the family group in the current study was that a support group or organisation for family members would help them better understand

why their family member has offended, and act as a source of mutual help. The importance of support groups is cited in the research literature; Mezey (2007) states that the views of service users and carers are central to understanding needs, identifying barriers to services, improving users' experiences and promoting trust and engagement with services. Given that many offenders do not trust their GPs enough to ask them for help, and offenders with complex problems may not view primary healthcare as the solution to their needs, it is crucial that service users and carers are involved in strategic groups at all stages of the process, from policy development to decisions about care plans and risk assessment and management. In this research, professionals indicated that such a support mechanism would help reduce stigma and strengthen families as a '*protective factor*', and would also help '*minimise risk*' and re-offending. This also appears to be something that offenders '*want*' with regard to treatment interventions. There has been much research on the benefits of multi-systemic therapy (MST), which involves family participation in treatment interventions to identify problems and develop solutions (Howell, 2003). Howell states that it is particularly useful with young offenders and their parents. In this regard the main goal is to assist parents in dealing with their child's behavioural problems, but it also works with the family to help build positive social support networks. MST has been shown as an effective treatment for delinquency in serious and violent youths (Howell, 2003). Such a model in a modified form would be worth exploring for the population this research was concerned with.

There was a general agreement amongst all groups about the need for a healthy lifestyle for offenders and that, where possible, hospitalisation should

be avoided, as it tends to induce a dependence and could result in the loss of patient coping skills: *'hospital is not like the real world'*.

This study explores 'what works' in community forensic mental health teams from three different perspectives, patient/offender, family, and professional. Treatment interventions are a critical component to risk management and ultimately reducing risk, and psychological theories act as a guide to 'what works' and how to reduce risk. However, to make a long-term difference to offender rehabilitation and to add to existing research, listening to the population being treated and their family can add to our knowledge base. Research has indicated that people with a mental illness express a strong desire to be informed about, and actively engage in, their treatment plans (Storm and Davidson, 2010; Woltman and Whitely 2010). However, in practice they may not be provided with the opportunity to engage in decisions about their treatment (Storm and Davidson 2010).

The final area of importance identified in the treatment themes of the present study was the promotion of a 'stepped down' process/facility between secure accommodation and community living. This is explained as a gradual transition in the form of accommodation and support for those moving from prison or a psychiatric institution into the community. The professionals were very vocal on this subject. They advocated a supported living environment that would be *'well supported and managed'* by staff and would have *'continuity of care'* from the patient's previous secure environment. Research highlights the importance of accommodation for offender rehabilitation; in a recent Ministry of Justice study nearly two in five prisoners (37%) stated they would need help

in finding a place to live when they were released, and three-fifths of prisoners (60%) believed that having a place to live was important in stopping them reoffending in the future (Williams et al.). Suitable accommodation is clearly a significant risk management factor in offending.

Key Points for Consideration

With regard to treatment interventions for a mentally-disordered offender/patient, the areas significant to this study and future research include:

- *The importance of therapeutic forensic groups for mentally-disordered offenders:* In this study all three groups agreed that participation in offence-focused therapeutic groups was an important treatment intervention which helps to reduce risk and re-offending. The need for follow-up work after a group ends was highlighted as important as was the sense of 'loss' that both patients' and families feel when a group finishes. The benefit of offending behaviour groups is well documented in the offender rehabilitative literature (McGuire, 1995; McGuire, 2000; Friendship et al., 2002 and 2003). This study adds to the existing literature, but in particular emphasises the importance of therapeutic groups from the perspective of those who participate in the groups, that is the offenders themselves;
- *Groups as an 'agent of change':* In this study, professionals viewed groups as 'agents of change', almost perceiving them as particularly powerful and therefore endowed as an influential entity. More research in the Northern Ireland context would be helpful;

- *The role of therapeutic alliance in groups:* As with the risk management theme the importance of the therapeutic relationship between, patient, family, and therapist was highlighted. This adds to existing research in this field. Bordin (1994) suggested the alliance in the early stages of treatment is built principally on a positive *emotional bond* between therapist and client (such as trust, respect, and liking), their ability to *agree on the goals* of the treatment, and their establishment of a mutual *consensus on the tasks*. Friedlander, Escudero and Heatherington (2006) state that the working alliance in family therapy involves the creation of a strong emotional bond as well as negotiation of goals and tasks with the therapist. However, the dynamic between the family and the therapist is important to consider when treating this population, given that they may have a powerful role to play in the patient's risk management plan;
- *Groups as a social outlet:* As well as their therapeutic benefit, all three groups viewed the social aspect of group participation as important. For many people, participating in a group may be their only social- and peer-related activity. These relational benefits links with the 'Good Lives' model, where it is argued that addressing a person's social needs is just as important as targeting their offending when it comes to recidivism (Maruna, 2010). Ward et al. (2007) highlights that some of the most effective treatment interventions are those offered by non-correctional interventions such as volunteer-driven approaches. Ward advocates that sometimes people get into trouble because they don't have good things going on in their lives. Thus addressing this absent

factor through social outlets can have a positive impact, not only on the quality of the person's life, but also in terms of a reduction in the risk of re-offending, (Ward et al., 2007);

- *Family support group:* In this study the family and patient group highlighted the need for a support group for families of offenders/patients. They suggested a group that is both educational in terms of information about offending and risk, but also acts as a support mechanism for families of offenders. Multisystemic therapy is used extensively with young offenders and their families and has proved successful, (Howell, 2003). This may be worth considering for the mentally-disordered population given that the family of such a population may be more likely to be involved in risk management plans considering the complex needs of this group;
- *Step down approach:* The need for a 'step down' approach when moving from secure accommodation to community living was emphasised powerfully by the professional group. The family group were also in support of this need. This issue highlights a gap in the provision of services for mentally-disordered offenders in Northern Ireland and is an area that needs urgent attention.

Treatment Responsivity

Ensuring that treatment is responsive to both risk and need was identified as an important factor. This position is reflective of the 'What Works', 'Risk Need, Responsivity', and the 'Good Lives' models. Forensic groups were identified by the families as being responsive to patients' needs and were viewed as a

'successful intervention' in terms of changes in a person's mental health and ability to refrain from offending. Again, this mirrors research findings relating to the effectiveness of offending behaviour programmes (Friendship, et al. 2002 and 2003; McGuire 2002, Blackburn, 2004). McGuire (2002) stated that using structured offending programmes in community settings results in an average reduction of 40% in recidivism. In addition, a meta-analysis by Wilson, Bouffard, and MacKenzie (2005) examined 20 studies of group-oriented cognitive behavioural programs for offenders, and found that CBT was very effective for reducing their criminal behaviour. In their analysis, representative CBT programs showed recidivism reductions of 20-30% compared to control groups. Future research could usefully evaluate the re-offending of those treated through offending behaviour groups compared with untreated offenders in the long term.

The results highlighted the importance of motivation, with professionals arguing that it is a central and key component for treatment gains to be made. However, whilst professionals felt that families could help motivate patients and *'look out for release triggers'*, families felt they needed more support and input from professionals as there is a limit to what they can do: *'you can only do so much..'* It is interesting to note that families stated that a good understanding by professionals was important: *'they need to know their patients better'* was one view expressed. Likewise patients also felt that they required more input from professionals. Patients' did acknowledge the benefits of therapeutic groups as a motivator in their treatment: *'gives me something to look forward to'*. Given the obvious benefit in terms of reduction in re-offending that groups provide (Lipsey and Landenberger, 2006; Lipsey, Chapman, and

Landenberger, 2001). it is clear that forensic therapeutic groups are a treatment modality that works. This is not only in terms of victim reduction (the number of victims offended against), but also in terms of an increased sense of wellbeing for the patients themselves. Motivating offenders to change is therefore a critical element of forensic practice for professionals (McMurran and Ward, 2004). Motivational techniques have been devised by Miller and others (Miller and Rollnick, 2002) to increase the likelihood that individuals will engage in treatment. In motivational interviewing the clinician expresses empathy, encourages reasons for change, and rolls with resistance. Motivational interviewing is an important aspect of the therapeutic alliance between therapist and offender (McMurran, 2002). The research suggests that a therapeutic alliance is a critical success factor in treatment change with offenders (Marshall et al., 2010).

Other research from Scotland and England confirms that offenders particularly value getting help from their supervisor with practical problems such as unemployment and lack of accommodation (Shapland, et al., 2011).

Research in the area of treatment responsivity (DeMatteo et al., 2010), highlights that different professional groups focus on the different needs of the mentally-ill offender. That is, psychiatrists focus on medication, psychologists on personal factors, such as a client's insight into their offending behaviour, and social workers focus on post-discharge living arrangements; this is an issue that warrants further research.

Ward (2004) has argued that the principle of treatment responsivity is that treatments should be tailored to offender characteristics, such as learning

styles, cognitive abilities, and personality characteristics. In the context of the 'Good Lives' model, an offender's problem may lie with their lack of skills and abilities to attain primary goods by legitimate means. This once more highlights the importance of adopting a multi-modal approach when working with offenders, and illustrates the usefulness of the 'Good Lives' model that goes beyond risk management.

Key Points for Consideration

With regard to treatment responsiveness for a mentally-disordered offender/patient, the areas significant to this study and future research include:

- *Therapeutic Groups:* This study has highlighted the importance of therapeutic groups as a treatment modality that is responsive to the needs of offenders. This mirrors existing research in this area (Friendship, et al. 2002 and 2003; Harper and Chitty, 2005). McGuire's meta-analyses (2000) reviewed the effectiveness of cognitive behavioural groups, showing a reduction in re-conviction rates for those individuals who participated in the groups. It would be useful to explore specific elements of groups and what works in general;
- *Motivation:* Motivation was identified as an important factor in treatment change by all three groups in this study. There is a wealth of existing research in this area highlighting the importance of motivation in reduction of risk (McMurrin, 2002; McMurrin and Ward, 2004). Most of the research emphasises the role of the professional (Marshall, et al., 1999). In addition to supporting this theory, the current study emphasises the role of the family in facilitating change. Although this

study highlights the fact that family members are willing to do this, they also stressed the importance of professional support. The opportunity to develop a better 'support model' should be researched; not only should professionals be motivating the offender, but they should also be encouraging and supporting their family, who are key agents in their change;

Professional Involvement: The need for professionals to be more involved in a patient's treatment and care was identified as important. As with previous themes, the role of the therapeutic alliance was once more emphasised. This is clearly an important issue for both family and patients.

Collaboration and Support

In the current study poor communication between teams was identified as an important issue: *'seems to be a lack of communication... they don't work well together'*. A further issue identified by patient and family groups was a perceived lack of support in the context of a patient moving from hospital/prison to community living. Issues such as having practical help with *'day to day living'* and a *'phased approach'* were also raised. The professional group stressed the importance of consistency between services in addressing transition; for example, between mental health and forensic services, or between secure services, such as prison and hospital, and community living.

Research in this area suggests that despite the fact that collaboration and support between and within teams is identified as critical for effective treatment and risk management, professionals frequently encounter numerous problems

when trying to work effectively together (Bryne and Onyett, 2010). For example, professional rivalries, different disciplinary perspectives, and ideas for care result in conflict (Shaw, Heyman, Reynold, Davies, and Godin, 2007). Treatment planning can also be affected by team leadership and staff training (Fichtner, Stout, Dove, and Lardon, (2000). Clarke (2004) identified those who work with offenders as having a '*critical occupation*' that requires personal resilience and support. It would appear essential, then, that forensic services work effectively as teams, collaborating and supporting each other.

Furthermore, it would appear that teams, within forensic mental health settings in particular, struggle to be effective. One suggestion for this situation is that there is a lack of training in how to work within a professional team and also in how the teams are created, perhaps perpetuating power imbalances between professionals (Shaw et al., 2007). If the research and evidence suggests this as a problem, then it is not surprising that patients and families are becoming aware of the tensions, as identified in this study. It would thus appear important to ensure that teams are equipped to work effectively in order to provide the best possible service to the patient and their families.

McLoughlin and Geller (2010) created a framework for conceptualizing effective mental health treatment planning that sets out three integral components of a treatment planning system. Firstly, team structure, focusing on structure, membership, leadership and clarity of the team. Secondly, content, concentrating on the documentation of treatment planning. Finally, the planning process, examining how teams work together, such as the frequency and nature of meetings, and the inclusion of patients. In the present study it would appear that professionals, patients, and families are concerned

about the structural component of the teams, i.e. how the teams work together. The present study highlights the need for better working arrangements; professionals state that there '*needs to be greater access... and joined up working*'. As effective team working ultimately impacts on the quality of service delivery and outcomes, it would seem prudent for forensic mental health teams to take cognisance of this model (McLoughlin and Geller, 2010).

Key Points for Consideration

With regard to collaboration and support, the areas significant to this study and future research include:

- *Being Inclusive:* Including patients and families in a patient's treatment and risk management plan in terms of development and execution;
- *More transition support:* Providing more help for patients moving from hospital/prison to community living, such as assistance with '*day to day living*' and a '*phased approach*' to transfer;
- *Increased Awareness:* Being aware of the potential impact of poor communication on service delivery;
- *Team Model:* The adoption of a team model, such as McLoughlin and Gellers' framework, which helps teams work together in an effective, efficient, collaborative, and mutually-supportive manner.

Family Involvement and Support

As expected with regard to family involvement and support, the patient and family groups were the most vocal on this subject. It was strongly advocated by all three groups that more support should be offered to families whether in

the form of educative groups on mental illness and offending behaviour or more individual support from the patient's key worker. The patient group felt this was necessary, as from their perspective the *'family know you best'* and they *'should be involved more in patient care'*. A review of the research literature in this area indicates that key life events such as acquiring a stable partner can increase the likelihood of desistance from offending by acting as a source of informal monitoring and social support (Sampson and Laub, 1993). Research has also found that rebuilding ties with family, friends, and the wider community, and developing new pro-social relationships through work or marriage are important aspects of desisting from crime (e.g. McNeil and Weaver, 2010). It would seem judicious for organisations engaged in the mental health and offending field (for example health trusts, probation and police) to also work closely with families to ensure positive relationships can be developed and sustained by patients. Ongoing support from families appears to significantly reduce the likelihood of re-offending (Deakin and Spencer, 2011).

Both the patient and family groups advocated the need for the development of a formal group for families that would not only provide education about mental illness and offending behaviour, but would also assist in ongoing support regarding managing risk. Many family-based intervention programmes, focusing on improving parenting skills and relationships within the family, have traditionally been used to prevent the onset and continuation of juvenile offending (McGuire, 2002; and Healy, 2012). Systematic reviews of these programmes have found significant effects on juvenile recidivism (Healy, 2012). Unfortunately, their use with adults has not been evaluated, despite

strong evidence that one of the most significant triggers of change and abstinence from offending is the strength of family relationships. This is reported by patients in this study: *'they know the person best they need to know everything about the illness so that when something goes wrong they know what steps to take'*. Healy (2010) in her study of desisters and non-desisters in Ireland found that the desire to live up to family responsibilities was one of the biggest triggers for the decision to abstain from offending.

The type of family-based intervention is also a central consideration. Dowden and Andrews (1999) completed a meta-analysis of several family-based interventions. They found that programmes treating women offenders had the strongest results, and also identified effective targets or 'needs' for family-based interventions. The strongest positive association came from interventions which focused on interpersonal criminogenic needs (family processes, attachment, affection, and anti-social associates) followed by those which focused on personal needs (anti-social cognition and self-control). In the present study, some patients expressed a desire for acceptance from their family, *'to see past what the person has done and learn to accept you'*. This relates to family processes of attachment, acceptance, and affection. Furthermore, research would suggest that strong attachments trigger the motivation to change because they provide emotional support, the prospect of new social roles, and models of pro-social behaviour (Liebrich, 1993). All three groups advocated the necessity for more family involvement, treatment groups, and courses, and the professional group considered that a support network would *'help educate about how to manage behaviours or even how to manage the legal or court system'*. The findings from this study correspond

with existing research, indicating the need for appropriate family-based interventions (Healy, 2010; Visser et al., 2004).

Key Points for Consideration

With regard to family involvement and support, the areas significant to this study and future research include:

- *Supportive families can help reduce risk:* This research study indicates that professionals, families, and patients believe that the support of a family can significantly reduce offending. Existing literature in this area is concurrent with this finding (Visser et al., 2004; Richards et al., 2009; McNeill and Weaver, 2010; Healy, 2010);
- *Family-based intervention:* Developing an intervention that addresses the needs of both families and offenders is a recommendation from this study. There are a number of well-researched interventions available that should be explored further to identify their relevance to the population in the current study (Visser et al., 2004; Sampson and Laub, 1993).

Psychological Wellbeing

The present study highlighted differences in how social outlets promote an offence-free life. The patient group view relationships and social outlets as a protective factor; the family group focussed on activities and the need for them to be responsive to individual need, whilst the professional group focused on treatment services responsive to needs. As stated previously, in relation to offending behaviour, the formation of positive relationships can be a trigger for

change for the better. Research indicates that when offenders develop strong emotional ties with members of their wider networks they are more likely to take into consideration feelings of 'others' when deciding whether to re-offend or not (Caverley and Farrall, 2011). Being trusted by others, which includes both intimate and non-intimate relationships, has proven to be a strong motivating factor for sustained desistance from crime (Caverley and Farrall, 2011). Social outlets and recreational opportunities can also encourage desistance by providing access to more pro-social networks. Changes in social circumstances are often accompanied by improvements in psychological wellbeing (Caverley and Farrall, 2011).

Research studies have also found that persistent offending is often characterised by low levels of self-efficacy (Ward and Brown, 1984; Ward, 2002). This issue was identified in this research study, with patients feeling that positive relationships are a protective factor and help them desist from crime by helping them '*stay away from people you know you are going to get into trouble with*'. A '*befriending scheme*' was suggested as a treatment mechanism by families.

Stigma and being labelled by your offence or mental illness was a problem identified by all three groups in this study. Professionals voiced concerns that people may have problems accessing services and pro-social outlets due to the stigma of their offending behaviour. Families also expressed concern that people are often '*labelled with a mental illness*' and that there is a common misconception that mental illness is '*untreatable*'. Maxwell and Morris (1999) argue that the primary relevance of stigmatization is that it leads to others shunning offenders and treating them as outcasts, which may provoke a

rebellious and criminal reaction from them. Research has identified that this is particularly the case for individuals convicted of sexual offences (Marshall, et al., 2010). A number of individuals with this offence type participated in this study. Unfortunately, poorly-informed media campaigns of 'name and shame' have encouraged public outcry. This has the effect of labelling offenders, and in turn may serve to heighten social isolation, potentially leading to a return to offending behaviour (Maxwell and Morris, 1999). The development of networks of support and treatment involving the offender and the wider community have significant benefits in reintegrating offenders into the community in a positive and safe manner. A public awareness and education programme, possibly driven by government, is required to help shift cultural attitudes and dispel many of the commonly-held myths and misconceptions about offenders and mental illness. For the participants in this study the therapeutic relationships between patient and professional and family member and professional were identified as helpful in managing the effects of stigma. This again emphasises the important role that professionals play in a forensic patient's life, and that this relationship is a critical factor in successful treatment and desistance from offending.

Key Points for Consideration

With regard to psychological wellbeing, the areas significant to this study and future research include:

- *Stigma*: Stigma has a negative impact on re-offending and increases the likelihood of offending behaviour;

- *Social Outlets and Relationships:* Social outlets and relationships are seen as a protective factor against offending, and can increase self-efficacy and psychological wellbeing.

Public Perceptions and Awareness

Within the current study, the family group were particularly strident in voicing their concerns about public perceptions and the particular impact on the psychological wellbeing of patients, as stated in the previous section. Professionals supported the view that stigma is still an ongoing issue for patients and families, and that more education for the public on the treatability of mental illness and offending behaviour is required. For families and patients ‘*fear*’ was a word used frequently. Fear was used in the context of what ‘*others*’ may think as well as fear of relapse into illness or re-offending. Some patients experienced fear in the context of being publicly ‘*labelled*’ due to the nature of their offending, especially sexual offending, and possible retribution by others.

How others see offending and mental illness is a significant issue in the successful rehabilitation of offenders. Considerable research has been undertaken in the area of public perceptions relative to stigma and labelling. Wood and Francis (2007) conducted an analysis of the British Crime Survey (2005/6) and identified that an estimated 35% of individuals in England and Wales are worried about being physically attacked by strangers and 36% are similarly worried about being mugged or robbed. The group with the highest concern was the young female population (age 16-24). Research has identified two groups of offenders whom the public are most concerned about:

those with mental health problems, and sexual offenders. Both these populations were included in this current research. Appelbaum (2001) identifies the mentally-disordered as of the most concern to the public. With regard to sex offenders, West (2000) identified a strong public demand for punitive action, driven partly by media influence, for those who offend against children. Given this position, it is perhaps not surprising that offenders with a mental illness experience stigma and are fearful of the public. Many of the families of offenders feel that this is a shared stigma, which causes deep anxiety and family breakdown.

Public perceptions and views have a significant impact on whether someone will participate in, and/or benefit from, treatment. Stigmas can produce significant social effects, and generally induce shame in those who are branded. In offenders, particular those who have sexually offended, this can cause silence, secrecy, and concealment (Austin, 2004). Shame can have a ripple effect, not only impacting on the offender themselves but also their immediate and extended family. It would appear that the offence impacts on the ability to acquire employment and seek primary human goods, an innate desire of all human beings, as professed by the 'Good Lives' model (Ward, 2002). Braman (2004) stated that the inability of released prisoners 'to earn a decent living and support a family was far more shameful than their criminality. So, the stigma of criminality leads to the shame of being unable to support one's children, to help one's mother and so forth' (165-166). In the current research, the *'fear of something bad happening again'*, as quoted by a family member, is evidence of the 'ripple effect' and its impact on family members. Despite public education in this field, it would appear that both offenders and

their families still experience shame and stigma, which has a real impact on their ability to reintegrate into society and benefit from treatment, and ultimately impacts on their likelihood of re-offending. One participant in this study stated *'the less the public know the better.....they can ruin your life for good'*. This is clear evidence of the impact of adverse public perception, the creation of stigma, and the causation of silence, secrecy, and concealment.

In the present study, the negative impact of the Northern Ireland 'Troubles' on recovery and rehabilitation was also explored. Professionals felt that the conflict impacted on how much information a person would share in treatment, particularly if participating in group treatment; *'people are reluctant to divulge information about their background'*. The living environment and area one lives in can also impact on treatment and the motivation to remain within treatment. For example, one patient argued that living in a polarised community can prevent you from accessing a service from *'someone on the other side of the community'*. This was also supported by a mother from the family group who professed that she often chooses not to call the police when her son is unwell due to fear of how her community will react to the police when they arrive: *'where I live people don't like the police and act up, throwing stones at police cars'*. It is clear from these findings that aspects of the Northern Ireland culture can have an impact on whether someone will benefit from treatment or not. This supports research that argues that many people do not access or adhere to mental health treatments because of perceived costs to their wellbeing (Watson and Corrigan, 2002).

It is clear that stigma, lack of public education, awareness of the potential for rehabilitation of offenders and Northern Irish culture, and the legacy of the

'Troubles', impact on patients, their families, and the ability of professionals to fully implement treatment and rehabilitation programmes. Although initiatives are continually being developed and improved upon to address these issues, much more work is necessary.

Key Points for Consideration

With regard to public perceptions, the areas significant to this study and future research include:

- *The Northern Ireland culture:* for some patients and family members, where they live can impact on whether they will access services;
- *Stigma and shame:* the negative perceptions of the public, and the absence of suitably-informed awareness regarding mental illness and offending behaviour remains prevalent in society, and significantly impacts on the wellbeing of offenders and their families, as well as their ability to reintegrate back into society and benefit from treatment;
- *Education:* increased education for the public (including certain sections of the media) on the treatability of mental illness and offending behaviour, and the ability of rehabilitation to reduce public risk, is required in order to help defuse poor and ill-informed perceptions, whether they are privately held or publicly voiced.

Living Environment

In relation to living environment there was a strong consensus from the professional group that, where possible, people should be integrated into the community with appropriate support. This is reflected in the research

literature, where it is suggested that offenders who are integrated into society and feel a welcomed part of that society are less likely to re-offend, compared to those who feel isolated and stigmatised (Maruna, 2010). This reflects the need for professionals to work not only with the offenders, but also with their families and the wider community, for example employers and voluntary groups, to locate offenders in a suitable supported environment. Some of the patients in the present research study identified an active support network as important: *'twenty four hours help if needed'*. This was also echoed by both the family and professional groups. Deakin and Spencer (2011) found that positive support is likely to have a significant impact on desistance from crime, particularly for offenders after release from custody. Obtaining appropriate living environments for offenders is a critical support requirement.

One type of accommodation suggested in this study is *'supported living'*. This is typically where the individual is living in a house in the community which has access to twenty-four-hour support, usually with a professional on site at all times. Professionals were very clear in this study about the need for a *'stepped down approach'*, incorporating suitable living arrangements when a person moves from secure accommodation, such as prison or hospital, into the community. In Northern Ireland, specialist accommodation of this kind for people with forensic mental health needs is limited. Many offenders end up accessing hostel accommodation, which may not be appropriate for people with mental health needs, and can often expose individuals to a negative peer group. Having a stable living environment is known to support desistance from offending as it can increase the chances of employment (Harper and Chitty, 2005). In reviewing the research and literature in this area, Sapouna et

al. (2011) found increasing evidence that it is more effective to re-house ex-offenders into the mainstream rather than into hostel accommodation. Indeed, this has been advocated by all three groups in the current study. However, securing mainstream accommodation may be more of a long-term goal for some individuals, as sustaining such accommodation requires the ability of the ex-offender to manage money, and many do not possess the necessary life skills to do this. All of this reflects the importance of the 'Good Lives' model (Ward, 2002). The evidence suggests that treatment and rehabilitation of offenders should not be just offence-focussed. A holistic approach that addresses all elements of an individual's life appears to be what works.

A '*good area*', meaning a neighbourhood without anti-social or similar behaviour, or a troublesome reputation, was also identified by patients as important. Again, this reflects the importance of a positive peer group. In the present study patients reported being fearful of ending up back in crime simply because of peer pressure and the area they live in. Research undertaken by the Ministry of Justice on the accommodation backgrounds and needs of newly-sentenced prisoners (2012) supports this view. This research found that three-fifths (60%) of prisoners believed that having a place to live was important in stopping them from re-offending in the future. The implications of the findings of the present study are that securing an appropriate place to live with the right social and economic supports available may help prevent re-offending. '*Tailor to individual needs*', '*twenty four hours help, if needed*', '*give people a good chance*' were statements made by patients and families in pursuit of their case.

Key Points for Consideration

With regard to living environment, the areas significant to this study and future research include:

- *Step down approach*: a targeted step down approach from prison/hospital to community living will help a person integrate back into society better;
- *Living place and support*: where a person lives impacts on the likelihood of reoffending. The living environment needs to be appropriate (house, apartment, hostel, supported living, etc.), located within a ‘*good area*’ with good access to appropriate supports, and should not be influenced by a negative peer group.

Professional Characteristics

With regard to professional characteristics, all three groups felt that this had no meaningful influence on the working relationship between patient and professional. In responding to the specific question about the influence of cultural background on the therapeutic relationship, professionals emphasised the importance of personal self-awareness and being non-judgemental. For example, ‘*you need to be aware of your own self and prejudices*’, and the ‘*the nature of the relationship is central to the overall outcome in treatment*’. Patients stated that in relation to cultural background ‘*it shouldn’t matter*’, and families stated ‘*everyone should be treated the same*’.

In the present study, ‘professional characteristics’ was identified as a key theme in the risk management and rehabilitation of mentally-disordered

offenders. The information obtained implies that a strong therapeutic relationship between therapist and offender will reduce recidivism and help improve mental wellbeing.

The need to develop self-awareness is well documented in the research literature pertaining to working therapeutically with offenders. Clarke (2008) documents the importance of detailed attention to one's own wellbeing when working with forensic patients, stating that if this is not adhered to, personal effectiveness can be compromised. Scott (1989) states that therapeutic intervention with criminals is one of the most demanding areas of mental health work; a vital professional characteristic to possess, therefore, is resilience.

Other characteristics identified as important in the present study included empathy, rapport, and trust. Indeed, these were seen by all three groups as just as important as the professional's *'technical skills'*, such as training and qualifications. The significance of a high-quality patient/therapist relationship has been identified through research as a protective factor from offending behaviour, which has been endorsed in this study by the patients (offenders) and family groups. Marshall, et al. (1999) illustrated the importance of effective therapist characteristics and behaviours such as warmth, respect, and use of positive reinforcement. They argued that these characteristics are essential for treatment effectiveness and go above and beyond the 'What Works' and 'Risk-Need-Responsivity' models which they profess do not provide therapists with enough tools to engage with offenders in therapy. In addition, Ward and Maruna (2007) stated that the 'Risk-Need-Responsivity' model did not provide enough guidance about what to actually do to address risk factors. The

findings of the current study support Marshall's argument. All three groups; patients, families, and professionals, feel that the role of a patient's key worker was critical in risk management (as identified earlier in the risk management theme) and that treatment success was largely determined by the relationship developed between the key worker or therapist and the patient. Therefore, although the 'What Works' and 'Risk-Need-Responsivity' models provide excellent guidelines in terms of best practice in risk managing offenders they are limited in providing specific guidance as to how to actually do this.

McGuire (2001) stated that therapists should develop styles of interacting that will engage the client group; typically he argued that multi-modal, active participatory programmes are most effective. He also went on to say that therapists should use language that is easily understood. The Sainsbury Centre carried out a review of offending behaviour programmes in 2008 and found that the offenders whom they consulted with in their research confirmed the importance of establishing a good relationship with the facilitator. The findings of the current study support this finding and underline the crucial role that appropriate professional characteristics play in successfully delivering programmes.

However, in this study it is not just the relationship between the key worker/therapist and patient that was identified as important. Emphasis was also placed on the relationship between the key worker and the patient's designated family member, who will have been identified as a key component in the patient's risk management and rehabilitation plan. Whilst the therapeutic alliance between the therapist and the patient's designated family member

was found to be important in this study, an area deserving of future research is how that alliance may be developed for greater patient benefit.

In this study, a significant comment was made by a professional in the context of professional characteristics. This identified that '*a belief in change*' was necessary to assist in the rehabilitation of patients. This research would argue that professionals need to have a core belief and psyche that offenders can change, before they even engage in therapeutic work. Birgden (2004) commented that '*finding the will and way*' in staff to facilitate change in offenders is an important factor. Birgden argues that in order to successfully engage offenders in rehabilitation programmes, staff need to enhance a culture towards rehabilitation. Andrews (2001) stated that the behaviour of correctional staff (prison staff) is influenced by cognition, social support, behavioural history, and personality. Issues of organisational culture and staff motivation need to be addressed before rehabilitation programmes can be implemented. Although this study examines rehabilitation in the context of the community, the issues with regard to the characteristics of staff who work with this population are the same. Certainly, people who work with offenders not only need to have the appropriate skills and qualifications to do their jobs, but also, and more fundamentally, there has to be a core belief, exemplified through their professional characteristics, that people can change, desist from offending, and should have the opportunity to access a 'good life'.

Key Points for Consideration

With regard to professional characteristics, the areas significant to this study and future research include:

- *The importance of the therapeutic alliance:* In research this has been identified as one of the most critical success factors in offender treatment rehabilitation (Marshall et al., 2010; Bordin, 1994). Empathy, warmth and trust were identified as important professional characteristics. Appropriate training and support for staff working with offenders is therefore critical;
- *The therapeutic alliance between professionals and family may be just as important:* One of the most strongly-endorsed findings in this study is the importance of appropriate professional characteristics. However, in research this is often discussed in the context of patient and therapist (Bordin, 1994; Horvath et al., 2011; Wampold, 2001). This current study has highlighted its significance with regard to risk-managing a patient and ultimately the risk of re-offending;
- *Core Belief in Change:* Professionals in this study highlighted the importance of having a 'core belief' that people can change. This goes beyond training for staff in rehabilitation of offenders and raises the question of the recruitment and selection of people who work with offenders. Selection of the right professional is relevant given that working with offenders has been identified through research as a 'critical occupation' in terms of the need for personal resilience and the other characteristics identified in this study (Clarke, 2004 and 2008).

Governance

Most previous research studies which examine how satisfied patients are with a service, as noted by Theidke (2007), appear to be based on patients'

experiences at one time, rather than their experiences over a lifetime. Most patients in the current study had been recipients of a forensic service for at least a year and some for several years.

All three groups acknowledged that additional resources would improve services. A typical professional view was *'I would love to be able to develop better social supports, employment opportunities and therapeutic groups, but money is the biggest obstacle'*; families emphasised the need for *'better staff levels'*.

Partnership working was identified as important when working with multidisciplinary teams, improving the accessibility of the forensic service was seen as important by both the professional and family groups, and the need for increased finance and resources for treatment delivery was seen to be a significant issue.

The Northern Ireland Bamford Review for Mental Health and Learning Disability (2005/6) proposed that community forensic services should be developed in a planned and strategic manner by partnerships comprising of professionals from mental health and learning disability, service users and carers, commissioners and providers of services, and representatives from the wider community and from criminal justice agencies. This review also recommended that services should be comprehensive in terms of assessments and treatment and should also be accessible to service users. Appropriate funding should be available in accordance with a long-term plan that ensures the sustainable development of the service. The current research study highlights some gaps with regard to the Bamford recommendations.

Accessibility requires improvement as does partnership working between services. These are governance areas that require further work and are part of the recommendations to be taken forward from this research study.

Interestingly, the professional group felt that governance, resources, and funding were of no significance if '*the patient is not motivated to change*'. Motivating offenders to change is clearly a major obstacle in risk reduction. The 'Good Lives' model provides a framework for incorporating factors that have been shown to be of importance in enhancing offender motivation. The 'Good Lives' approach is used within the treatment programmes delivered by the community forensic mental health team whom the participants of this study are patients of. This research study has identified the value of this approach, particularly from the perspective of the patient and family groups, who feel that a patient's physical, mental, and social needs should be met in addition to their criminogenic needs. Therefore, governance arrangements will only be effective if the correct treatment model is being applied.

Key Points for Consideration

With regard to governance, the areas significant to this study and future research include:

- *Treatment Approach*: This research identified the importance of governance arrangements sitting within the right treatment approach, which from this study has been identified as the 'Good Lives' model;
- *Funding and Resources*: The need for additional funding and resources to develop treatment services was identified as important by professionals;

- *Partnership working:* The need for improved partnership working was highlighted as an issue to be addressed by professionals;
- *Accessibility:* All three groups felt the forensic service could improve their accessibility for patients.

In the next chapter the findings from the three studies will be discussed in the context of the research aims and hypotheses. In addition, the research process will be reviewed, and recommendations for future research will be made.

CHAPTER 7

SUMMARY and RECOMMENDATIONS

7.1 Introduction

This final chapter provides a summary of the research and makes recommendations for improving treatment interventions for mentally-disordered offenders in the community.

The research was undertaken in three studies, namely:

Study one: *The relevance of rehabilitation models; the view of patients, families and professional groups* (focus groups);

Study Two: *Treating forensic mental health patients in the community; comparison of patients, their families and professional groups* (questionnaires);

Study Three: *The views of clients, families and staff in relation to structure, function and efficacy of forensic mental health teams* (semi-structured interviews).

The significance of the study's findings to the research aims and hypotheses is reviewed. The added value of the research to existing literature in the field of what works with mentally-disordered offenders is highlighted. The research process is then evaluated and recommendations for further research are made.

7.2 Research Objectives, Aims and Hypotheses

The principle objective of this research was to explore what works with mentally-disordered offenders from a Northern Ireland perspective. Data was collected from three different groups involved with community forensic mental health services, the patient, the family, and the professional. The research was based on interventions provided by a local Community Forensic Mental Health Team.

This research study is the first of its kind to be undertaken in this setting in Northern Ireland. The focus of the research was twofold:

- An examination of treatment interventions that ‘work’ best with mentally-disordered offenders in the community, and;
- The client group and professionals’ perceptions of interventions and treatment with mentally-disordered offenders.

There were a number of aims and hypotheses to be explored, namely:

1. **Aim & Hypothesis:** Aim: Whether interventions and treatment programmes delivered by the Community Forensic Mental Health Team in Northern Ireland adhere to empirically-based rehabilitative models for offenders. Hypothesis: It was hypothesised that the Community Forensic Mental Health team deliver treatment interventions that are empirically-driven and evidence-based.
2. **Aim & Hypothesis:** Aim: How satisfied offenders and their families are with the community forensic service; the value they place on the service, and their understanding of the current approaches and

rehabilitative models adopted and applied. Hypothesis: It was hypothesised that the three groups would report satisfaction with the service received from the Community Forensic Mental Health Team.

3. **Aim & Hypothesis:** Aim: To explore the relationship between the therapist and the offender. Hypothesis: It was hypothesised that the three groups would identify the importance of a strong therapeutic relationship between therapist and offender for treatment intervention and risk management.
4. **Aim & Hypothesis:** Aim: To explore the legacy of the 'Troubles' in Northern Ireland on the treatment and rehabilitation of offenders and their families. Hypothesis: It was hypothesised that the legacy of the Troubles may have impacted negatively on the treatment and rehabilitation of mentally-disordered offenders receiving a service from a CFMHT in Northern Ireland.

A key aim of this research was to explore what works from a service-user perspective. The literature review identified an absence of research in this area. With regard to the patient as a service user, there appears to be a sense in some research that people with a diagnosis of mental illness or learning disability are not able to provide valid views (Weinstein 1981). Goodwin et al. (1999), however, argued for a moral obligation to include mental health service users in research. In this present study, all service users willingly gave their consent for involvement. In particular, patients and family members valued having their opinions heard, and were able to freely articulate and present their

opinions, which were suitably facilitated by the research methods and locations chosen.

7.3 Summary of Main Findings and Implications

7.3.1 Introduction

In reviewing the literature, three key theories were identified as being significant to the development of risk management and interventions with mentally-disordered offenders. These included the 'What Works' model, McGuire (1995), the 'Risk-Need-Responsivity' model, Andrews and Bonta (1994), and the 'Good Lives' model, Ward (2002). In each of the three studies undertaken the importance of these models in offender rehabilitation was endorsed. However, it appears that within the context of this current research and the community forensic mental health team, the model that 'sits' the best for each of the service user groups is the 'Good Lives' model, (Ward, 2000). This was initially identified through the focus groups in study one, where patients, families, and professionals commented on the importance of positive relationships, pro-social activities, appropriate accommodation, and support groups. The finding was further endorsed in study two. Finally, the semi-structured interviews in study three provided more evidence for the importance of the 'Good Lives' model for all three groups. The three studies together produced a series of relevant findings which have important implications for delivery of the CFMH service.

Effective treatment interventions are a critical component in risk management and ultimately in reducing risk. The three studies acknowledged the high treatment value of therapeutic groups. In study one, the three focus groups

identified forensic therapeutic groups as being important; for example, cognitive-based offending behaviour programmes. This was relevant in terms of providing people with the opportunity to be reflective and learn from past behaviour. The questionnaire analysis in study two supported this finding. The results from study three indicated a general concurrence across all three groups that forensic groups are an essential treatment intervention.

The key findings for each study and how they relate to the three studies and the aims, objectives, and hypotheses are discussed next.

7.3.2 Summary Findings

The overarching finding is that all three studies produced important results for service delivery and future research. Pursuing an integrated analysis approach from the results and related discussions in the three studies has enabled a final and more inclusive discussion to take place. Firstly, the findings, limitations, and relationship to the aims, objectives, and hypotheses will be discussed. Secondly, the ten themes identified in study one will be explored as individual platforms in this final discussion embracing all three studies.

Relationship to Aims, Hypotheses and Objectives

The primary aim of study one, which utilised a focus group approach, was to enable and facilitate the views of service users with regard to what works for mentally-disordered offenders. This study identified ten themes relevant to the three groups (patients/mentally-disordered offenders, family/carers, and professionals). These— were: risk management, treatment interventions,

treatment responsiveness, collaboration and support, family involvement and support, psychological wellbeing, public perceptions and awareness, living environment, professional characteristics, and governance. The focus groups established a pathway for more detailed investigation in pursuit of the aims, hypotheses, and emerging issues in studies two and three.

1. Aim and Hypothesis: *'treatment interventions for mentally-disordered offenders are grounded in empirically-based rehabilitative models'. It was hypothesised that all three groups would perceive this as the case and report the value of therapeutic interventions.*

The findings of the three studies support the above research aim and hypothesis. Statements from service users that show evidence of this and, in particular, the application of rehabilitative models by the CFMHT includes:

- *'Groups (forensic offence-focussed groups based on rehabilitative models) are good at addressing general life problems as well as offending issues'* (patient);
- *'Forensic cognitive groups are a positive treatment intervention'* (family);
- *'A holistic approach ('Good Lives' model) should be adopted by services with regard to treatment, structures, teams, and the activities patients engage in'* (professional).

2. Aim and Hypothesis: *'Professionals, offenders, and their families would report being satisfied with the service they receive from the Community Forensic Mental Health Team'.*

The focus group and semi-structured interview findings endorsed the above hypothesis. Offenders and their families appear to be satisfied with, and value, the service they currently receive from the CFMHT. This was also the case with professionals; however, a few recommendations for service improvement were made by the professionals. These were mainly around better working arrangements and communication between CFMHT and other services. Family and patient groups agreed with professionals that increased awareness of the role and services of the CFMHT provide was needed.

Examples of supportive evidence from focus groups and semi-structured interviews include:

- *'More awareness that the service is available we didn't know about it until the offence happened'* (family);
- *'Needs to be greater access and joined up working'* (professional);
- *'Seems to be a lack of communication'* (family);
- *'More support between services is required'* (patient).

3. Aim and Hypothesis: *'The three groups would identify the importance of a strong therapeutic relationship between therapist and offender for treatment intervention and risk management'.*

The above hypothesis was largely endorsed by all three groups.

Examples of supportive evidence from focus groups and semi-structured interviews include:

- *'The therapeutic relationship is central to getting people engaged and to gain maximum benefit from intervention'* (professional);

- *‘Knowing the person inside out’ (family);*
- *‘The nature of the relationship is central to the overall outcome in treatment’ (professional).*

4. Aim and Hypothesis: *‘The three groups would report a negative impact of the Northern Ireland ‘Troubles’ on the treatment and rehabilitation of offenders’.*

The above hypothesis was largely endorsed by the three groups. Examples of supportive evidence from focus groups and semi-structured interviews include:

- *Yes I feel the troubles have had an impact (family);*
- *Especially for X, he is very vulnerable; people take advantage of him, certain people around us within our area (family);*
- *With respect to patients and the troubles there’s a lot of post traumatic anxiety around and in Northern Ireland we are still dealing with the legacy of that (professional);*
- *So the ‘troubles’ does certainly create an additional work load which isn’t adequately funded. So now we have this legacy of a dependence on tranquilisers and anti-depressants to deal with these problems before we can look at psychological therapies that these people need (professional);*
- *I suppose for some people they may refuse a service from someone on the other side of the community (patient).*

Overall, the evidence from all three studies confirms the validity of the four hypotheses. There were a number of significant differences between the three groups identified in study two, questionnaire. These were in relation to:

Risk Management

- In particular, the role of the key worker, which in the current study was endorsed more so by the patient and family groups than the professional;
- Attention to individual needs in a treatment and risk management plan was also endorsed more by the patient and family groups;
- The impact of being risk-averse on rehabilitation was endorsed more by the professional group;
- The impact of the Northern Ireland culture on risk management, which was endorsed more by the professional group.

Public Perception and Awareness

- The role of the Northern Ireland culture with regard to wellbeing was endorsed more by the professional group;
- With regard to professional background, the patient and family group felt that the cultural background of a professional matters.

Themes which were endorsed particularly strongly by all three groups included:

- The importance of treatment interventions, and in particular the therapeutic relationship between professional and patient/offender;

- The role of a patient/offender's family in terms of support and risk management.

This evidence also validates existing empirical literature relating to the importance of evidence based treatment interventions, the relationship between satisfaction and improved mental wellbeing, and the critical role the therapeutic relationship plays in reducing recidivism.

7.3.3 Study One: The Relevance of Rehabilitation Models; the view of Patients, Families and Professional groups

There were a number of key findings from study one. Overall, study one highlighted the benefits of involving the service user in research. Patients and family members identified the focus group process as helpful, not only in terms of having their voice heard, but also as being an active participant of a group, and having the opportunity to share problems and issues in managing a family member with a mental disorder and offending background. One of the key recommendations that arose from the family member focus group was the need for a 'support group' specifically designed for family members. This idea was also reinforced by the professional and patient groups and expressly developed into the theme 'family involvement and support'. In further reviewing the academic literature in this area, research would suggest that involving service users improves self-esteem (The Sainsbury Centre, 2001). The opinions of service users are of inestimable value and can lead to positive changes in attitudes and beliefs. Indeed, in this research study the opinions of service users produced the critical evidence leading to the development of the

ten core themes identified as significant within the area of what works with mentally-disordered offenders.

The development of these themes is one of the most significant findings from this research. The ten themes identified are what are considered important from a service user perspective when working with mentally-disordered offenders in the community. They are also reflective of the major rehabilitative models selected to be reviewed in this study. The ten themes established the platform for further research within studies two and three. In these studies the aim was to test the significance and value of the themes and the key issues arising within, from both a quantitative (questionnaire) and qualitative (semi-structured interview) approach.

7.3.4 Study Two: Treating Forensic Mental Health Patients in the Community; Comparison of Patients, their Families, and Professional Groups

There were a number of significant differences between the three groups in study two as outlined above, in the areas of risk management and public perception and awareness. The remaining themes were largely endorsed by all three groups. In the risk management theme the role of the key worker and attention to individual needs in a risk management plan were endorsed more by the patient and family groups than the professional group. Interestingly, this is very much reflective of both the 'Good Lives' model and affirms the importance of the therapeutic relationship. For example, in the risk management theme, emphasis was placed on the role of the key worker with the patient, and the family group endorsed this more than the professional

group. In the treatment responsivity theme the role of the professional in motivating a person to change their behaviour was positively rated. In the collaboration and support theme, professionals endorsed the importance of good working relationships on treatment impact and rehabilitation. The value placed by patients and families on this relationship is one of the most significant findings to emerge from this research study and is reflective of the research literature (Bordin, 1994; Horvath et al., 2011; Wampold, 2001; Marshall et al., 2003). What has emerged as a very important dynamic in this research study is that the service users and, in particular, the mentally-disordered offenders and their families endorse and support this evidence.

In the questionnaire, the relevance of Northern Ireland culture to risk management was endorsed slightly more by professionals. However, in the interviews pertaining to this issue the family members were more vocal on the adverse impact of the 'Troubles' on rehabilitation. This is a significant finding in terms of the impact of the Northern Ireland conflict on treatment and rehabilitation and the legacy of the 'Troubles'. For some families, issues such as ongoing paramilitary conflict or activity in their local area can make it difficult for them to cooperate with the PSNI; for example, a PSNI visit to their home could be observed by paramilitary groups, generating apprehension and fear to patients and families. This consequence (real or imagined) also impacts on disclosure to professionals within treatment, and a fear of being honest regarding past history and current behaviours. Such a contextual situation emphasises the importance of the therapeutic relationship and potentially why family and patients are strong advocates of it.

The family focus group (study one) strongly argued for a support group for families, which was supported by the questionnaire analysis (study two). The need for a family support group was strongly endorsed by all three groups. From this research, the value that professionals and patients place on the role of family members is clear. They are seen as a critical component in an offender's risk management plan. The 'Good Lives' model makes reference to the importance of pro-social relationships as a protective factor against offending. An implication from this research is a need for more support for family members in undertaking this role, including the establishment of a suitably defined support group facilitating family expression of concerns, participation, and mutual support. In reviewing the research literature, many studies outline the importance of the family in an offender's rehabilitation (Richards et al., 2009); however, there appears to be a lack of structured interventions where the family are actively involved. The research literature points to family involvement for adolescents who offend, rather than adults, through multi-systemic therapy. Whilst early intervention is key, it is important to acknowledge that not all families may have access to such timely interventions, or be motivated to attend at a time when required.

7.3.5 Study Three: The views of clients, families, and staff in relation to the structure, function, and efficacy of forensic mental health teams

Study three reinforced the findings of studies one and two. Once more key areas of significance and importance included the therapeutic relationship, the role of the key worker, the role of the family, the importance of social outlets that are responsive to a person's age, level of ability, and interests, and the value of therapeutic group work.

Research areas that were conceivably not identified as significant from the focus groups and questionnaires (studies one and two), and which as a consequence were afforded more attention through the semi-structured interviews included:

Stigma: Despite public promotion and awareness of mental health and offending, and accessibility of treatment interventions, a great deal of stigma is still experienced directly and psychologically by service users. Such a public view, frequently manifested through disappointingly poorly-informed media expression, creates obstacles to effective treatment not only for the patients, but also for the professionals delivering the service and the families, whose support is crucial. Existing research supports this finding, for example Maxwell and Morris, 1999 and McAlinden, 2005. Caverley and Farrall (2011) report the positive effects ex-offenders feel when they are involved by the public in providing talks about their experiences, for example, coming off drugs. According to Caverley and Farrall's research, the sense of reward and achievement felt is a motivator for staying away from crime.

Step down approach: This was initially identified as important through the focus groups by the professional group. The questionnaire results highlighted a statistical difference between the professional and patient group, with a greater endorsement from the professionals. This policy was strongly advocated by professionals and also endorsed by family members. The 'Pathways to unlocking secure mental health care' – Mental Health Report (Centre for Mental Health, 2011 - October) states: 'the majority of people in secure services will have been in custody for quite some time and will have been supported to a high level. The leap between secure settings and the

community represents a huge step in the pathway, and one which patients and staff alike will find anxiety provoking and challenging' (20). It was recommended in this current research study that patients should have more support when moving from a secure environment, such as prison or hospital, into the community, and that the transfer should be a planned, phased approach specific to the needs of each patient.

Motivation: It is a substantive finding from the study that a person needs to be motivated to engage in treatment and offence-focussed work, and that the family have a meaningful role to play in motivating and supporting patients to positively engage in suitable treatment. McMurran (2002) and McMurran and Ward (2004) highlight the importance of motivating an offender from a professional perspective. The findings indicate that the role of the family in motivating a person to change is strongly advocated by all three groups: 'the family know you best, they need to know everything about the illness so that when something goes wrong they know what steps to take' (study three semi-structured interview, patient response). The role of the family in supporting offenders was one of the most strongly-endorsed themes in this research. Liebrich (1993) suggests that strong attachments trigger motivation to change, because of the emotional support provided. It is the emotional support that the family is able to provide that appears to be of more importance to the offender than the professional support.

Living Location: Regardless of good motivation, a positive therapeutic alliance and helpful forensic group outcomes, if the environment where a person lives is not therapeutically appropriate or recovery-supportive, then this could be a

risk factor for further offending or deterioration in mental health. Williams et al. (2012) identified that having an appropriate place to live on release from prison is an important risk factor for an ex-offender. The findings from this study support existing research (Williams, et al. 2012; Harper and Chitty, 2005; Shapland et al., 2011). They also reflect the ethos of the 'Good Lives' model which advocates that rehabilitation for offenders should not just focus on offending issues, but in addition address all the important elements in a person's life, including where they live.

Professional Characteristics: Having a non-judgemental approach is regarded as important for professionals. '*Treating everyone the same*' and '*not imposing your own values*' were identified as important characteristics that a professional should exhibit and be endowed with. The inference from the findings is that a strong therapeutic relationship between the offender and therapist will increase mental wellbeing and reduce recidivism. The importance of the therapeutic relationship involving effective characteristics and behaviours of a therapist is widely cited in offender rehabilitation research (Marshall et al., 1999; Marshall et al., 2003; Ward and Maruna, 2007; McGuire, 2001; Andrews, 2001). Such existing research advocates that therapeutic alliance and associated characteristics such as, warmth, empathy, respect, and positive reinforcement are essential for effective treatment effectiveness. The findings from this study, which looks at therapeutic alliance from the perspective of the three different groups, supports existing research.

7.4 Concluding Remarks

The ten themes identified in study one and continuously reinforced as important for the risk management and rehabilitation of mentally-disordered

offenders makes a primary contribution to the 'What Works' literature for mentally-disordered offenders from the perspective of service users. A number of sub-themes arose through further exploration in the questionnaires and semi-structured interviews, which also concur with major rehabilitative theories in offender management. The one theory, however, which services users appear to endorse most strongly, is Tony Ward's 'Good Lives' model and this is important for the future work of CFMHTs.

In summing up, the ten themes and sub-themes significant to offender rehabilitation include:

Risk Management

- The role of the family in risk management;
- The role of the key worker in risk management;
- The therapeutic alliance between patient, family, and key worker;
- Importance of social outlets.

Treatment Interventions

- Therapeutic forensic groups;
- Groups as an agent of change;
- Therapeutic alliance within groups;
- Groups as a social outlet;
- The need for a family support group;
- The need for a step down approach.

Treatment Responsivity

- The importance of therapeutic groups;

- The importance of motivation when engaging offenders in treatment.

Collaboration and Support

- Being inclusive of patients and families when developing treatment plans;
- Adopting an integrated team approach.

Family Involvement and Support

- Supportive families can help reduce risk;
- Family intervention work for adult offenders;
- Support group for families.

Psychological Wellbeing

- Stigma is an ongoing issue for people with mental health and offending problems;
- Pro-social outlets and positive relationships are a protective factor.

Public Perception and Awareness

- Northern Ireland culture has an impact on where some patients can live and their ability to access services;
- Increased education for the public about mental illness and offending behaviour is required.

Living Environment

- Where a person lives impacts on the likelihood of reoffending;

- A step down approach from prison/hospital to community living helps a person integrate better into community.

Professional Characteristics

- The importance of the therapeutic alliance;
- Procession of the essential characteristics beyond the academic requirements for holistic treatment;
- A core belief in change.

Governance

- Partnership working to improve outcomes;
- Accessibility of services;
- Adequately resourced and funded service arrangements;
- Governance arrangements being underpinned by empirically-based treatment approaches such as the 'Good Lives' model.

The data collected from this research has been important in terms of informing McGuire's 'What Works' theory and also Ward's 'Good Lives' model , both regarded as fundamental in the rehabilitation of offenders in the field of Forensic Psychology.

This research makes an important contribution to knowledge, including:

- Additional research findings on the 'What Works' theory in relation to CFMHTs in Northern Ireland;
- Additional research findings on the 'Good Lives' model in relation to CFMHTs in Northern Ireland;

- Increased learning about what is needed to ensure the delivery of an effective and efficient CFMHT (community forensic mental health team) that not only reduces the risk of offending, but also contributes to integrating mentally-disordered offenders into the community.

The Northern Ireland conflict has potentially impacted on the treatment and rehabilitation of offenders, in that people are still experiencing trauma from the conflict.

7.5 Evaluating the Research Process

One of the key strengths of this research was using a mixed-methods approach. This enabled the use of different methodological approaches to be adopted, which produced a rich set of data. A mixed-methods design acknowledges that all methods of data collection have limitations, and therefore advocates that the use of multiple methods can neutralize or cancel out some of the disadvantages of certain methods. As well as the individual strengths inherent in each approach, they can complement each other when used in an integrated way.

The area of research selected was complex. Some of the participants had multiple problems, both of a criminogenic and non-criminogenic nature. Mixed methods were required to best understand such complexities. In addition, the mixed-methods approach enabled the research to answer confirmatory and exploratory questions at the same time, for example, 'is the CFMHT adhering to McGuire's 'What Works' principles?' and 'what can we learn from mentally-disordered offenders in the community in relation to 'What Works'?' Being able

to explore and answer these questions facilitated construction and confirmation of theory in this research study.

A second methodological strength within this research was obtaining the perspective of service users. As stated earlier, research with service users appears to be limited; however, Goodwin et al. (1999) argued for a moral obligation to include mental health service users in research. Clearly, people with mental illnesses and offending behaviour do have a voice and have something valid to say – as this research proves. This research study demonstrates that they are in support of the major rehabilitative theories identified, and within a local Northern Ireland context they have made important suggestions for improving service delivery. The family participants in this study identified the process of participating in the focus groups as cathartic, and from this experience felt they would benefit from a support group for families of forensic patients. This research is different from other studies, in that it not only adds to existing academic literature, but the research process has also benefited the services users involved in it therapeutically.

7.6 Limitations of the Research Study

One of the key limitations within this study was the restricted number of participants. It proved difficult to recruit more professionals due to busy work loads and providing time to complete questionnaires and participate in semi-structured interviews. Furthermore, the patient and family numbers were somewhat low due to CFMHT having a reduced case load at the time of the research. A second limitation was the problem of being unable to collect recidivism data. The population within the CFMHT is small and the team is

relatively young, hence there have been no systems for recording re-offending data. There is also the added issue that not everyone who offends is 'caught' hence data may not be completely accurate.

The adoption of the mixed-methods approach, incorporating three related studies, helped to ameliorate the limitations.

It could be argued that the results of the study were influenced and biased unintentionally by the researcher who was also a 'therapist' to many of the patient participants and was also known to family members of the patient participants (the role of the researcher is important and is addressed in Chapter 3 section 3.14.).

This relationship may have influenced the responses provided in the qualitative studies as the researcher conducted the focus groups and semi-structured interviews herself. The point could be made that participants did not feel they could be entirely truthful about their experiences because the researcher was known to them. On the other hand, there was an evident participant ease and comfort factor that facilitated good communication and honesty in the engagement and responses due to the professional therapeutic alliance with the researcher and the deployment by the researcher of an effective moderating role, especially in the focus groups. Prior to undertaking the research, the researcher considered the issue of reflexivity, and debated the benefits of knowing the participants from the perspective of having an existing strong therapeutic alliance and how this might be an advantage in terms of the data obtained. In reality, a power dynamic did appear to occur when collecting objective data from those individuals who knew the researcher

extremely well, whilst still attempting to retain objectivity. The researcher was aware of this dynamic and took moderating steps to explore the views expressed to ensure that they reflected as far as possible the participant's experiences. On reflection, from the perspective of enhancing objectivity it may have been helpful to have employed a second researcher to compare data and examine for potential prejudices and subjectivities. A further possibility may have been the use of a reflective journal where the researcher logs the details of how she may have influenced the results of the focus groups and interviews. This may have served as a contributor to the final analyses and added to the overall study design by providing a documented first-hand account of any interview bias and the preconceptions that may have negatively influenced the findings. However, to address the potentialities of subjectivity an independent review of the data and analysis was undertaken and the researcher took steps in her role (see section 3.14) to ensure that the participant interactive engagements were as objective as possible.

The overall study design was ambitious in that it employed three separate studies. Whilst the researcher felt this added to the quality of the results obtained, the findings may have been further enriched through employing additional researchers to enhance, as stated already, issues of objectivity and reflexivity. However, positive feedback from the participants, several reviews of the data and analysis, and comparative evaluations of the results across the three studies reassured the researcher of the validity of the findings.

7.7 Impact of Research on Professional Role

The research has impacted on my professional role as a forensic psychologist in a number of ways.

Firstly, the findings from the research have contributed to the development of a new treatment programme for individuals who sexually offend, entitled the New Beginnings Treatment Programme. The significance of the 'Good Lives' model, particularly from the perspective of the family and patient user groups, resulted in the incorporation of this model into the treatment programme. For example, the programme makes reference to the importance of addressing offending from a more holistic viewpoint so that a person's emotional, social, and physical needs are addressed in addition to their offending, which is the essence of the 'Good Lives' model. The need for greater communication and co-working as identified by family members and professionals has also been addressed. Those teams who refer patients to be assessed for the New Beginnings Treatment Programme and who then receive a service from the forensic team are offered awareness training in this treatment intervention. This ensures they are aware of the purpose of the work with the patient and thus can reinforce learning points from the programme where required. The training has also resulted in a better co-working relationship between professionals.

Secondly, the findings have also impacted on the approach we adopt in our treatment of patients referred to the community forensic mental health team. There is a greater awareness of the need to work more effectively with professionals who refer patients for treatment. For example, we now present

our risk assessment findings verbally to the referrer, through case review meetings as well as in a written report. This has resulted in more open channels of communication and better co-working relationships.

Thirdly, as a psychologist the research has highlighted the importance of the scientist-practitioner role and the added value of research. The research has enabled me to use existing knowledge from the evidence base and literature on forensic psychology to address specific problems in the practice of my work as a forensic psychologist. This has been helpful in solving problems and addressing challenges and opportunities in my work – for example, how to work more effectively with sex offenders – and has contributed to the development of a specific treatment programme for them.

Fourthly, the research has better informed me of the value of service users, particularly patients and their families, in the research process.

7.8 Implications for Future Research

There are a number of implications for future research both at an academic and service-delivery level. Future research could expand the numbers at a local level to other CFMHTs in Northern Ireland. In addition, examining re-offending data would provide more qualitative results. Further longitudinal studies would facilitate the examination of the rehabilitative models in more detail.

In this study, the role of the family in offender risk management and rehabilitation was identified as a significant finding. Exploring in more detail the role families have to play in risk management and treatment may assist in

the development of therapy programmes for adult offenders that also incorporate families.

More work is required in exploring the legacy of the 'Troubles' on treatment and rehabilitation. This is undoubtedly a very sensitive topic to explore with offenders, particularly since some are still embroiled in paramilitary activities, or feel threatened by this group and thus are reluctant to talk about their experiences. It is clear however that the 'Troubles' potentially have an ongoing impact on offenders, and can influence their ability to engage in treatment and sustain a treatment programme.

This research clearly indicates that offenders and their families, as service users, have valid opinions and that these opinions are reflective of evidence-based offender rehabilitative models. This research dimension alone is an important finding; however, it also paves the way for further research involving offenders and their families, perhaps looking in more detail at the specifics of rehabilitative models and how well they meet their needs.

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APPENDICES: 1-18

APPENDIX 1: Research Ethics Approval letter



Office for Research Ethics Committees Northern Ireland (ORECNI)

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HSC REC 2

18 October 2010

Professor Robert Edelmann
Professor of Forensic and Clinical Psychology
University of Roehampton
Whitelands College
University of Roehampton
London
SW15 4JD



Dear Professor Edelmann

Study Title: Evaluating the effectiveness of community forensic
mental health teams - a Northern Ireland perspective
REC reference number: 10/NIR02/38

Thank you for your letter of 07 October 2010, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a sub-committee of the REC. A list of the sub-committee members is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a **favourable ethical opinion** for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Providing Support to Health and Social Care

APPENDIX 2: Roehampton University Ethics Final Approval

Dear Carolyn,

Ethics Application

Applicant: Carolyn Mitchell

Title: Evaluating the effectiveness of community forensic mental health teams - a Northern Ireland perspective

Department: Psychology

Ref: PSY 10/ 051

I am pleased to confirm that the above application has been approved by Chairs Action on behalf of the Ethics Board. We do not require anything further in relation to this application.

Regards,

Jan

Jan Harrison

Ethics Administrator

Tel: 020 8392 5785

Room 208, Grove House, Froebel College.

Roehampton University

Any opinion or other information in this e-mail or its attachments that does not relate to the business of Roehampton University is personal to the sender and is not given or endorsed by Roehampton University.

Roehampton University is a company limited by guarantee incorporated in England under number 5161359. Registered Office: Grove House, Roehampton Lane, London SW15 5PJ. An exempt charity.

APPENDIX 3: Participant Information & Consent Form

Patient



Version 4 19th October 2010
Unique ID Code:



CONFIDENTIAL

PARTICIPANT INFORMATION & CONSENT FORM (Patient)

Title of Research Project: Evaluating the effectiveness of community forensic mental health teams: a Northern Ireland perspective.

This consent form has the Roehampton University logo as the research is being undertaken for fulfilment of a Psych D in Forensic Psychology with the University of Roehampton, London.

Purpose of research

The purpose of the research is to evaluate the effectiveness of the Southern health and Social Care Trust's Community Forensic Mental Health Team (CFMHT) from the perspective of a number of different people, namely the Professional, the Patient and the Carer. This means how well the service is working. The research has been reviewed by the Ethics Committee in Roehampton University and also Office of Research and Ethics Committee Northern Ireland. These are independent groups of people and are there to protect your interests. Both Committees have given this study favourable opinions. Before you decide to take part in the research I would encourage you to read the Information Sheet to understand why the research is being done and what it would involve for you. I will go through the information sheet with you and answer any questions you may have. This should take about 20 minutes.

Brief Description of Research Project:

I am undertaking research on how well the Southern Trust Community Forensic Mental Health Team is working. A community forensic mental health team helps people who have a mental illness and are at risk of getting into trouble with the police. As you use this service I feel it is important to ask you what you think about it.

Before you decide to take part in the research I would like you to understand why the research is being done and what it would involve for you. I will go through this information sheet with you and answer any questions you may have. This will take about 20 minutes. Part one tells you about the study and what will happen to you if you take part. Part two gives you information on the conduct of the study. Part three is the consent form. This is where you are asked whether you are willing to participate in the research study.

Part One

Why have you been invited to take part?

I have invited you to take part in the research because you receive a service from the CFMHT. It would be extremely helpful to hear of your views and experiences of the CFMHT. It is intended that this will help us improve the service for you and your family.

Taking part in this research is entirely voluntary. It is up to you to decide to join the study. If you agree to take part I will ask you to sign a consent form. You are free to withdraw at any time without giving a reason.

What will I be asked to do?

In this study you will be asked to:

- Participate in an interview and a focus group. The focus group will ask you what you think about the community forensic service. You will be in a group with about 6 or 7 other people. It will last for about 1 hour. The interview will also ask you what you think about the community forensic mental health team and will last for approximately 1 hour. The interviews and focus groups will be audio tape recorded for data collection purposes. All information will be held confidentially (no one except me will be able to hear it) and you will not be identified by name on the tape recordings.
- Fill out a questionnaire asking you what you think about the community forensic mental health team. This will take about 10-20 minutes of your time.

Part Two: Conduct of Research Study

Possible risks or benefits

There is no risk involved in this study except your time. There is no direct benefit to you also. However, the results of the study may help us to develop a better service for you.

Right of refusal to participate and withdrawal

If you agree to take part in this study you need to know that you can stop at any time if it is too hard for you.



You can also withdraw any time from the study without any negative impact on your treatment. You may also refuse to answer some or all the questions if you don't feel comfortable with those questions.

Confidentiality

Everything you tell me in this study will remain confidential (between you and me). This means nobody except me will have access to it. Your name and identity will also not be disclosed at any time. Whilst confidentiality will be upheld information provided will be summarised for research reports or publications for use of relevant professionals.



However if you tell me something that affects your own safety or the safety of others I will have to report this. If I do I will only tell important professional people who can help.



Your Key Worker (CPN/Social Worker) GP and Psychiatrist will be informed that you are taking part in this research. I will only do this with your prior consent. These people will be informed simply that you are participating in the research study. No further information will be disclosed.

Part Three: Consent

Evaluating the Effectiveness of Community Forensic Mental Health Teams: a Northern Ireland perspective

Name of Researcher: Carolyn Mitchell

Consent Statement:

1. I confirm that I have read and understand the information sheet dated 19th October 2010 version 4 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

Please initial box

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

Please initial box

☐

3. I understand that data collected during the study may be looked at by individuals from the research team at the University of Roehampton, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data.

Please initial box

☐

4. I agree to my GP and Psychiatrist being informed of my participation in this study.

Please initial box

☐

5. I agree to take part in the above study

Please initial box

☐

I agree to take part in this research, and am aware that I am free to withdraw at any point. I understand that the information I provide will be treated in confidence by the investigator and that my identity (who I am) will be protected in the publication of any findings. I understand that I will be given a copy of this consent form to retain (keep).

Name **Name of person taking consent**

Signature **Signature**

Date **Date**

Please note: if you wish to withdraw the data you have provided in the interviews or focus groups you may do so. You can do this by providing the Investigator, Carolyn Mitchell (details below) with your unique ID code on the top of the first page of this form. If you wish to do this please do as soon as possible after the focus groups and interviews as information that has already been used in a completed study or publication cannot be withdrawn. If you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the University of Roehampton and ask to speak to the Director of Studies.

Director of Studies Contact Details:

School: Human and Life Sciences

University Address: Roehampton University, Whitelands College, Holybourne Avenue, London, SW15 4JD

Telephone: +442088714219

Investigator Contact Details: Carolyn Mitchell, Consultant Forensic Psychologist

Name: Carolyn Mitchell

School: Human Life and Social Sciences

University address: Roehampton University, London

Work address: Pinewood Villa, St. Luke's Hospital Armagh

APPENDIX 4: Participant Information & Consent Form

Family



Version 4 19th October 2010

Unique ID Code:



CONFIDENTIAL

PARTICIPANT INFORMATION SHEET AND CONSENT FORM (Family/Carer)

Title of Research Project: Evaluating the effectiveness of community forensic mental health teams: a Northern Ireland perspective.

This consent form has the Roehampton University Logo as the research is being undertaken for fulfilment of a Psych D in Forensic Psychology with the University of Roehampton, London.

Purpose of research

The purpose of the research is to evaluate the effectiveness of the Southern health and Social Care Trust's Community Forensic Mental Health Team (CFMHT) from the perspective of a number of different people, namely the Professional, the Patient and the Carer. This means how well the service is working. The research has been reviewed by the Ethics Committee in Roehampton University and also Office of Research and Ethics Committee Northern Ireland. These are independent groups of people and are there to protect your interests. Both Committees have given this study favourable opinions. Before you decide to take part in the research I would encourage you to read the Information Sheet to understand why the research is being done and what it would involve for you. If you decide to take part in the research I will arrange to meet with you and go through the information sheet and answer any questions you may have. This should take about 20 minutes.

Brief Description of Research Project:

I am undertaking research on how well the Southern Trust Community Forensic Mental Health Team is working. A community forensic mental health team helps people who have a mental illness and are at risk of getting into trouble with the police. As you and your family member use this service I feel it is important to ask you what you think about it.

Before you decide to take part in the research I would like you to understand why the research is being done and what it would involve for you. I will go through this information sheet with you and answer any questions you may have. This will take about 20 minutes. Part one tells you about the study and what will happen to you if you take part. Part two gives you information on the conduct of the study. Part three is the consent form. Were you are asked whether you are willing to participate in the research study.

Part One

Why have you been invited to take part?

I have invited you take to part in the research because your family member receives a service from the CFMHT. It would be extremely helpful to hear of your views and experiences of working with the CFMHT. It is intended that this will help us improve the service for both patients and professionals.

Taking part in this research is entirely voluntary. It is up to you to decide to join the study. If you agree to take part I will ask you to sign a consent from. You are free to withdraw at any time without giving a reason.

What will I be asked to do?

In this study you will be asked to:

- Participate in an interview and a focus group. The focus group will ask you what you think about the community forensic service. You will be in a group with about 6 or 7 other people. It will last for about 1 hour. The interview will also ask you what you think about the community forensic mental health team and will last for approximately 1 hour. The interviews and focus groups will be audio tape recorded for data collection purposes. All information will be held confidentially (no one except me will be able to hear it) and you will not be identified by name on the tape recordings.
- Fill out a questionnaire asking you what you think about the community forensic mental health team. This will take about 10-20 minutes of your time.

Part Two: Conduct of Research Study

Possible risks or benefits

There is no risk involved in this study except your time. There is no direct benefit to you also. However, the results of the study may help us to develop a better service for you and your family member.

Right of refusal to participate and withdrawal

If you agree to take part in this study you need to know that you can stop at any time if it is too hard for you.

You can also withdraw any time from the study without any negative impact on the service you and your family member receive. You may also refuse to answer some or all the questions if you don't feel comfortable with those questions.

Confidentiality

Everything you tell me in this study will remain confidential (between you and me). This means nobody except me will have access to it. Your name and identity will also not be disclosed at any time. **Whilst confidentiality** will be upheld information provided will be summarised for research reports or publications for use of relevant professionals.

However if you tell me something that affects your own safety or the safety of others I will have to report this. If I do I will only tell important professional people who can help.

Your family member's GP and Psychiatrist will be informed that they are taking part in this study. I will only do this with their prior consent. Their GP/Psychiatrist will be informed simply that your family member is participating in the research study. No further information will be disclosed.

Part Three: Consent

Evaluating the Effectiveness of Community Forensic Mental Health Teams: a Northern Ireland perspective

Name of Researcher: Carolyn Mitchell

Consent Statement:

6. I confirm that I have read and understand the information sheet dated 19th October 2010 version 4 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

Please initial box

☐

7. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

Please initial box

☐

8. I understand that data collected during the study may be looked at by individuals from the research team at the University of Roehampton, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data.

Please initial box

☐

9. I agree to my family member's GP and Psychiatrist being informed of my participation in this study.

Please initial box

☐

10. I agree to take part in the above study

Please initial box

☐

I agree to take part in this research, and am aware that I am free to withdraw at any point. I understand that the information I provide will be treated in confidence by the investigator and that my identity (who I am) will be protected in the publication of any findings. I understand that I will be given a copy of this consent form to retain (keep).

Name Name of person taking consent

Signature Signature

Date Date

Please note: if you wish to withdraw the data you have provided in the interviews or focus groups you may do so. You can do this by providing the Investigator, Carolyn Mitchell (details below) with your unique ID code on the top of the first page of this form. If you wish to do this please do as soon as possible after the focus groups and interviews as information that has already been used in a completed study or publication cannot be withdrawn.

Further Information and Contact Details

If you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or if the researcher is a student you can also contact the Director of Studies.)

Director of Studies Contact Details:

School: Human and Life Sciences

University Address: Roehampton University, Whitelands College, Holybourne Avenue,
London, SW15 4JD

Telephone: +442088714219

Investigator Contact Details: Carolyn Mitchell, Consultant Forensic Psychologist

Name: Carolyn Mitchell

School: Human Life and Social Sciences

University address: Roehampton University, London

Work address: Pinewood Villa, St. Luke's Hospital, Armagh

APPENDIX 5: Participant Information & Consent Form

Professional



Evaluating Community Forensic Mental Health Teams Information Sheet and Consent Form on Proposed Research for Professionals

Title of Research Project: Evaluating the effectiveness of community forensic mental health teams: a Northern Ireland perspective.

This consent form has the Roehampton University logo as the research is being undertaken for fulfilment of a Psych D in Forensic Psychology with the University of Roehampton, London.

Before you decide to take part in the research I would like you to understand why the research is being done and what it would involve for you. If you decide to take part in the research I will go through this information sheet with you and answer any questions you may have. This will take about 20 minutes. The information sheet provides a brief description of the research and tells you about the purpose of this study and what will happen to you if you take part. A consent form is also attached. This is where you are asked whether you are willing to participate in the research study.

Purpose of research

The purpose of the research is to evaluate the effectiveness of the Southern health and Social Care Trust's Community Forensic Mental Health Team (CFMHT) from the perspective of a number of different people, namely the Professional, the Patient and the Carer. This means how well the service is working. The research has been reviewed by the Ethics Committee in Roehampton University and also Office of Research and Ethics Committee Northern Ireland. These are independent groups of people and are there to protect your interests. Both Committees have given this study favourable opinions.

Brief Description of Research

The aim of the research is to evaluate whether the Southern Health and Social Care Trust Community Forensic Mental Health Team (CFMHT) Northern Ireland, follows recommendations for working with mentally disordered offenders as outlined in the 'What Works' theory by McGuire (McGuire et al 1995). McGuire's 'What Works' is a significant theory in the field of Forensic Psychology and has provided a set of

principles for best practice in the rehabilitation of offenders. The theory advocates that services for offenders works best when:

- they are based on an explicit model of the causes of crime, drawn from empirically sound data;
- they have a risk classification – i.e. more intensive programmes should be targeted at high and medium risk offenders;
- they target criminogenic needs;
- they are responsive, so that offenders benefit from interventions, which are meaningful to them and delivered in a way that is appropriate to their learning styles;
- offenders are given the opportunity to practise new skills/attitudes and behaviour, and motivation should be addressed;
- the treatment method is skills-oriented, active and designed to improve problem solving in social interaction, based on cognitive behavioural techniques;
- programme impact is substantially influenced by the manner and setting of delivery (i.e. quality of delivery and programme integrity).

In 2006 ‘The Bamford Review’ (a review of mental health and learning disability including forensic services in Northern Ireland) set out a series of recommendations for how community forensic mental health teams in Northern Ireland should operate. We have identified no research in Northern Ireland as to whether CFMHTs have met these recommendations and indeed whether, in respect of CFMHTs, they are in line with McGuire’s ‘What Works’ theory.

Research Questions: The research will evaluate the effectiveness of the CFMHT against the ‘What Works’ theory. For example, has the service met the ‘What Works’ principles? If so how and if not why? The research will also evaluate whether the CFMHT has met the Bamford Review recommendations and explore whether these recommendations are relevant, taking into account McGuire’s theory.

Participants: Research will be undertaken from three group perspectives (1) client (patient) (2) carer (3) professional. The research should highlight lessons learned that will inform future policy development of CFMHTs. All patients currently known to the CFMHT will be asked to participate in this research. Thus if you have a patient that you have referred into this service and whom we are currently engaging in work with then they will be asked to participate in this research project.

Method of Research: The method employed in this research will be a Mixed Methods design. This design method has been selected as it incorporates techniques from qualitative and quantitative methods to answer research questions.

Qualitative: The first stage of the research will involve a series of focus groups and semi-structured interviews with a sample of the three groups. The groups include; patients, carers, professionals. The aim of the focus groups and semi-structured interviews is to evaluate from the above groups perspective:

1. Whether the principles of McGuire’s ‘What Works’ theory and the ‘Good Lives’ Model have been met;
2. Whether the 2006 Bamford Review recommendations have been met and;
3. Determine their attitudes towards the community forensic mental health team/service and perceived satisfaction and benefits of the service.

Quantitative: Questionnaires with the likert scales will be administered to assess people's attitudes, levels of satisfaction and perceived benefits towards a service.

Outcomes: The data collected from participants will be important in terms of informing McGuire's 'What Works' theory, fundamental in the rehabilitation of offenders in the field of Forensic Psychology. It is proposed that the research will be an extension of existing knowledge within these two areas. The research will inform CFMHT and policy makers in the Southern Trust as to what is working and why it is working. The research will also allow examination of how the CFMHT is really working and the perspectives of different service groups will be very informative and bring a new dimension to this area of work.

In summary the contribution to knowledge includes:

- Additional research findings on 'What Works' theory in relation to CFMHTs in Northern Ireland'
- Increased learning about what is needed to ensure the delivery of an effective and efficient community forensic mental health team that not only reduces risk of offending but also contributes to integrating the mentally disordered offenders into the community
- Contributing to increased public safety in the community through identifying 'what works' with mentally disordered offenders in the Southern Health and Social Care Trust.

Why have you been invited to take part?

I have invited you take to part in the research because you refer patients into the CFMHT. It would be extremely helpful to hear of your views and experiences of the CFMHT. This will help us improve the service for professionals, patients and their families.

Taking part in this research is entirely voluntary. It is up to you to decide to join the study. If you agree to take part I will ask you to sign a consent form. You are free to withdraw at any time without giving a reason.

What will I be asked to do?

In this study you will be asked to:

- Participate in an interview and a focus group. The focus group will ask you what you think about the community forensic service. You will be in a group with about 6 or 7 other people. It will last for about 1 hour. The interview will also ask you what you think about the community forensic mental health team and will last for approximately 1 hour. The interviews and focus groups will be audio tape recorded for data collection purposes. All information will be held confidentially (no one except me will be able to hear it) and you will not be identified by name on the tape recordings.
- Fill out a questionnaire asking you what you think about the community forensic mental health team. This will take about 10-20 minutes of your time.

Possible risks or benefits

There is no risk involved in this study except your time. There is no direct benefit to you also. However, the results of the study may help us to develop a better service for you.

Confidentiality

Everything you tell me in this study will remain confidential. This means nobody except me will have access to it. Your name and identity will also not be disclosed at any time. Whilst confidentiality will be upheld information provided will be summarised for research reports or publications for use of relevant professionals.

Consent Form

Evaluating the Effectiveness of Community Forensic Mental Health Teams: a Northern Ireland perspective

Name of Researcher: Carolyn Mitchell

Consent Statement:

11. I confirm that I have read and understand the information sheet dated 19th October 2010 version 4 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

Please initial box

☐

12. I understand that my participation is voluntary and that I am free to withdraw at any time.

Please initial box

☐

13. I understand that data collected during the study may be looked at by individuals from the research team at the University of Roehampton, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data.

Please initial box

☐

14. I agree to take part in the above study

Please initial box

☐

I agree to take part in this research, and am aware that I am free to withdraw at any point. I understand that the information I provide will be treated in

confidence by the investigator and that my identity will be protected in the publication of any findings. I understand that I will be given a copy of this consent form to retain.

Name **Name of person taking consent**

Signature **Signature**

Date **Date**

Please note: if you wish to withdraw the data you have provided in the interviews or focus groups you may do so. You can do this by providing the Investigator, Carolyn Mitchell (details below) with your unique ID code on the top of the first page of this form. If you wish to do this please do as soon as possible after the focus groups and interviews as information that has already been used in a completed study or publication cannot be withdrawn. If you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the University of Roehampton and ask to speak to the Director of Studies.

Director of Studies Contact Details:

School: Human and Life Sciences

University Address: Roehampton University, Whitelands College, Holybourne Avenue, London, SW15 4JD

Telephone: +442088714219

Investigator Contact Details: Carolyn Mitchell, Consultant Forensic Psychologist

Name: Carolyn Mitchell

School: Human Life and Social Sciences

University address: Roehampton University, London

Work address: Pinewood Villa, St. Luke's Hospital Armagh

APPENDIX 6: Participant Information & Consent Form

Letter to GP and/or Psychiatrist



Evaluating Community Forensic Mental Health Teams: A No Perspective

Letter to GP and/or Psychiatrist

Dear Sir/Madam

I am currently conducting research in conjunction with the Southern Health and Social Care Trust and Roehampton University London. The research is self funded and is for an educational qualification. The purpose of the research is to evaluate the effectiveness of the Southern health and Social Care Trust's Community Forensic Mental Health Team (CFMHT) from the perspective of a number of different people, namely the Professional, the Patient and the Carer.

The research has been reviewed by the Ethics Committee in Roehampton University and also Office of Research and Ethics Committee Northern Ireland. These are independent groups of people and are there to protect patients' interests. Both Committees have given this study favourable opinions.

What will the research involve?

As you have a patient currently receiving a service from the CFMHT the research will involve the research team making contact with this patient and inviting them to take part in the study.

They will be asked to complete a questionnaire and may be asked to participate in a semi-structured interview and focus group to determine their attitudes and feelings towards the CFMHT service.

The information collated will help determine how effective the CFMHT is working and improve the quality of the service we provide to patients with forensic mental health needs.

Many thanks for taking the time to read this letter. Please do not hesitate to contact me if you have any questions about this research.

Best regards

Carolyn Mitchell

Consultant Forensic Psychologist

Community Forensic Mental Health Team - 02837412470

APPENDIX 7: TOPIC GUIDELINES SCHEDULE FOR FOCUS GROUPS

STUDY 1: FOCUS GROUPS



TOPIC GUIDELINES SCHEDULE FOR FOCUS GROUPS

The following topics (areas) will be discussed:

- Satisfaction with the service provided by the community forensic mental health team
- Perceived benefits of the community forensic mental health service for patients and their families
- The range of service provision by the Community Forensic Mental Health Team
- Service users' needs being met
- Understanding of risk assessment and risk of offending
- Understanding of the benefits of group therapy (Good Thinking Skills Group) for service users
- Perceived impact of the service on re-offending
- Perceived impact of the service on mental health stability
- Engagement with service users family/carer
- Engagement with professionals who make referrals into the service
- Reintegration of service users into the community

NB: It should be noted that the above areas are not exclusive and additional areas can be added to during the focus group/interview discussion.

APPENDIX 8: Messages & Emerging Themes: Patient

STUDY 1: FOCUS GROUPS

Messages & Emerging Themes: Patient

Demographics of Focus Group

Gender	Diagnosis	Age Range
Male	Non Mental Health Problems/personality	20-30
Male	Paranoid Schizophrenia	20-30
Male	Paranoid Schizophrenia	30-40
Male	Paranoid Schizophrenia	30-40

Thematic analysis applied. Data transcribed verbatim. Data read, reread to look for patterns, themes, noted on side of page. Data was then coded and themed together. Following themes emerged. In brackets further below I have put model/theory each theme links into:

- **Treatment/Interventions:** treatment depends on the individual and should be responsive to their needs. Treatment not just about looking at forensic side also general well-being. CFT 'improved all aspects of my life'. 'as my life has improved the risk of anything happening has gone down. Everyone should be given the same standard of help and should be of a high standard.

In depth help for mental health needs is important: Perception that people offend because of poor mental health.

Feel confident that family are happy with treatment provided by the CFT.

Treatment needs to be timely 'if you start dipping CFT is on the ball'.

Treatment shouldn't always be related to risk level.

CFT helps motivate you to address mental health and offending. Assists with routine - Routine is important in treatment i.e. knowing appointment times etc.

Treatment is about 'support to hold on to'. Creating an anchor for future work and improving behaviour this avoids crisis.

Groups are good for tackling general problems and are a positive social outlet. Individuals would benefit from one to one work outside of groups. Parallel approach individual and group work at same time?

- **Awareness Raising:** there should be greater awareness for PSNI about the link between mental illness and offending behaviour 'explain to the cops your'e not wild like'.
- **Resources:** should be more. Patients aware of cut backs re resources.
- **Communication:** combination of written and verbal best. Understanding communication can be dependent on mood state. Patients want choice – written and verbal. Want to be able to take information away and read it. Content with how information is explained.
- **Accessibility:** CFT is accessible
- **Key Worker:** plays a significant role in risk management and general well-being. Having a named individual person assigned to your case. Someone who knows you well (familiarity). Trusting relationship. Critical that your key worker can pick up on the warning signs and are only a phone call away. However question of dependency?
- **Stigma Issues:** access to social life can be hindered by past offences, social rejection (chill factor).
- **Relationships and Social Interaction:** difficult to find appropriate social outlets. Need to be age responsive and safe outlets required. Sharing information with others who have mental health problems is positive e.g. access to gym via GP.
- **Holistic approach to treatment is best:** mental health better since engagement with CFT.
- **Environment:** home treatment preferable ('see real person') but willing to go hospital if it will be of benefit. Perception that patients house needs to be clean before home visits. Perception that you are judged by the condition and quality of your home (non-judgemental attitude important).

Home visits can be motivating be motivating as it makes you prepare for the visit but also unpredictable in terms of traffic delays and not always knowing the exact time professional will visit. A clinic appointment is more structured. A mixture of home and clinic visits is best.

CFT overall meets needs. Standard of care is good. The team is approachable and are able to answer any questions you may have. . Referral and waiting times good.

APPENDIX 9: Messages & Emerging Themes - Family

STUDY 1: FOCUS GROUPS

Messages & Emerging Themes - Family

Demographics of Focus Group

Gender	Relationship to Patient (Family member)	Age Range	Other dependents (children)
Female	Mother	60-70	No
Male	Father	60-70	No
Female	Wife	30-40	Yes
Female	Wife	30-40	Yes

Thematic analysis applied. Data transcribed verbatim. Data read, reread to look for patterns, themes, noted on side of page. Data then coded and themed together. Following themes emerged. In brackets further below I have put model/theory each theme links into:

Themes

- 1. Risk management**
- 2. Support**
- 3. Groups: Forensic Courses for MDO and courses for families**
- 4. Accessibility**
- 5. Continuity of care**
- 6. Responsivity re activities/groups**
- 7. Approach of Professional**
- 8. Motivation**
- 9. Stigma**
- 10. Fear**
- 11. Family as Advocate for patient**
- 12. Environment**
- 13. Communication**
- 14. Acceptability**

1. Risk Management ('RISK-NEED-RESPONSIVITY' Model)

- Professional skills- Team working could be better
- Interface and integration failures
- Communication - Clear and not mixed Messages
- Securing best match between risk and treatment - continuous development
- Service responsiveness weak

- Continuity of care – familiarity and trust missing
- Balancing Security with Recovery not fully appreciated – need better communication

2. Family Involvement and Support (Good Lives Model)

- Patient Participation and trust needs reinforced
- Family advocacy role to be enhanced and structurally recognised
- Peer advocacy – to influence choice missing
- Courses and training for family members to be developed by forensic team
- Forensic support group required for families
- Family psychological and practical needs- carers, children – overlooked and underestimated
- Balancing Security with Recovery – ‘you can’t get in but you can get out’ reference patients in a locked ward in a Psychiatric hospital
- Respecting patient rights but also family rights

3. Psychological Wellbeing - Reality and Perceptions (Good Lives Model and What Works)

- Families see forensic groups as a positive treatment intervention for patients
- Need for a shared understanding of difficulties and problems and what constitutes well-being for the patient and family
- Community, Family, Patient and Professional in tension as to what is reality and perception in the process
- Perception that recovery and reintegration will not happen or too high expectation that it will
- Clinical perspectives at variance with family realities
- Fear from patient regarding their own mental illness, hiding symptoms from professionals

4. Responsivity (‘RISK-NEED-RESPONSIVITY’ and What Works)

- Interventions need to be responsive to the patients’ needs. Criticisms of day care activities provided by hospital and local groups. Praise for forensic offending behaviour groups
- People with mental illness can be hard to motivate to engage in treatment – pressure on families to do this – difficult
- Families see forensic groups as a positive treatment intervention for patients

5. Local Environment (‘RISK NEED RESPONSIVITY’, Good Lives and What Works)

- Impact of NI culture and values – positive and negative
- Acceptability and respect of who we are and what we have – illness?

- Public arena chill factors e.g. perception by family of high visibility of patient relative in shopping centres
- Community stigma impacts ongoing, but diminishing – more needs done

6. Professional Characteristics ('RISK NEED RESPONSIVITY', Good Lives and What Works)

- Ability to exercise key skills of Empathy and Understanding that are patient specific
- Bridge Building with family and lead carers
- Creating the right atmosphere - *using the light, space, words, movement and touch to deliver the message of care- ensuring that the message of care is accepted*
- Failure to communicate properly with family
- Family Fear of professions – power, suitability, commitment

7. Governance (What Works)

- Ensuring the primary goal remains fixed on service user needs
- Better use of Resources – more focused and integrated approach
- Policy - flexibility to meet changing treatment scenes
- Making sure treatment location is appropriate for family access
- Consult families in proposed changes that may impact on their family patient
- Keeping rights and risks in balance and overall protect people and help them recover

APPENDIX 10: Messages & Emerging Themes - Professionals CJA and Accommodation

STUDY 1: FOCUS GROUPS

Themes: Professionals CJA and Accommodation Managers

Demographics of Focus Group

Gender	Profession	Age Range
Female	PSNI Sergeant	40 -50
Male	Manager of Probation Hostel	50-60
Male	Manager of Residential Housing	40-60
Female	Discharge Liaison Nurse NIPS	40-50
Female	Discharge Liaison Nurse NIPS	40-50

Thematic analysis applied. Data transcribed verbatim. Data read, reread to look for patterns, themes, noted on side of page. Data was then coded and themed together. Following themes emerged. In brackets further below I have put model/theory each theme links into:

- **Organisational arrangements:** There are good links between Prison, Police and CFT. Joined up approach to working and a 'circle of care'. Also recognition that CFT is an evolving service.
- **Care Management & Through Care:** Needs to be 'mapping' of a patient's journey from Prison to community. Links between prison and CFT are important in this regard. Should be proactive rather than reactionary 'care lead rather than reactionary way'.
- **Case Management:** CFT have small caseloads which is perceived as positive as this leads to better identification of risks and warning signs
- **Risk Management:** concerns about monitoring of offenders. Perception that CFT is an essential resource for managing risks in the community. However important that individuals working with offenders do not become complacent, 'familiarity breeds complacency'.
- **Concerns about how Trust Risk assessment (CRA) are being undertaken.** Poor risk assessment leads to deficiencies in treatment pathway and as a result poor outcomes. Risk assessments are being completed in a mechanical manner. Training need and perhaps a sample audit of risk assessments?

- **Public Safety:** preventative management is important when working with offender population. CFT have an important role in this. Public require education and awareness
- **Education:** CFT provide advice and guidance for agencies.
- **Environment:** needs to be 'very high tolerance levels of not anti-social but deviant type behaviour'. People as far as possible should be facilitated in the community if they can be safely managed.

Perception that individuals 'do better' if living in their own environment with the right supports. Environment needs to be the 'best fit' for the individual; this can be the home, or hospital. However there is acknowledgement that seeing the person in their own home is positive. There needs to be more supported accommodation for mentally disordered offenders.

Perception that hostels may not be the most appropriate environment for persons with a severe and enduring mental illness.

- **Step Down:** 'take the driving lessons to pass the test, not be the driver'. People are assessed on what they can do whilst in hospital but is it appropriate for this assessment to be transferred to the community? Big step from Shannon Clinic (secure accommodation) to community living. Needs to be more 'mapping' and step down approach from secure environments to community; 'structured step down' that is professionally managed and supported. Otherwise risk of failing.
- **Communication:** positive between CFT and agencies, good flow of information
- **Accessibility:** CFT is accessible
- **Professional Approach:** CFT is a targeted specialism, provides advice, guidance and support to agencies. Professionals knowing one another is an important factor to positive working arrangements, working from a sound evidence base is important.
- **Treatment/Interventions:** treatment depends on the individual and should be responsive to their needs. Group dynamics are important in managing difficult personalities. Recommendation for follow up work with individuals after group sessions to assist in managing difficult emotions that may arise after a group session.

Goal orientated approach should be adopted. Looking at what people can achieve, not just about the restrictions.

Treatment should be proportional to risk and need level.

Holistic approach in treatment is best. Realism in treatment required.

In groups some offenders feed off each other (sex offenders).

Need to be street wise about the street wise.

Professionals need to remind themselves why people have restrictions and probation orders.

Nature/nuture divides amongst some professionals

Has society failed some people? Sad when a person ends up in prison – that's an important message for society?

- **Resources:** more required to appropriately and safely manage people in the community. Accommodation is not always responsive or suited to a person's needs. Poor resources to manage high risk people. Concerns about Probation adequately monitoring offenders in the community.

Questions:

1. Should there be follow up of people who DNA
2. Should the scope of the service be extended to bring other vulnerable people into the net for assessment?
3. Role of the public in understanding risk management of offender

APPENDIX 11: COMPARATIVE SUMMARY OF AGREED TEN THEMES

STUDY 1: FOCUS GROUPS

1. Risk Management

Patient	Family	Professional; Psychiatrists	Professional - CJA and Accommodation Managers
<p>Everyone should get the same standard of care regardless of level of risk.</p> <p>Your key worker plays an important role in your risk management. They can pick up on warning signs.</p> <p>What Works + Responsivity</p>	<p>There needs to be a balance between security and recovery. Good Lives Model</p> <p>Securing the best match between risk management and treatment of the person. What Works + Responsivity</p> <p>Communication regarding a person's risk needs to be clear and without mixed messages (different professionals saying different things). What Works + Responsivity</p> <p>At times the Trust response to risk and need is weak.</p>	<p>Too much focus on risk management. Management are risk adverse - results in fear, negativity and defensive practice.</p>	<p>Small cases aid better risk management and identification of warning signs.</p> <p>Concerns about monitoring of offenders. CFT essential resource for risk management of offenders in the community. However need to avoid complacency due to familiarity.</p> <p>Concerns about how Trust risk assessments are being undertaken. Poor risk assessments lead to deficiencies in treatment pathway and poorer outcomes. The approach can be very mechanical – more training required?</p>

Patient	Family	Professional; Psychiatrists	Professional - CJA and Accommodation Managers
			<p>Preventative management is important. CFT important role in this.</p> <p>Education and awareness of public important.</p> <p>What Works + Responsivity</p>

2. Treatment Interventions

Patient	Family	Professional; Psychiatrists	Professional - CJA and Accommodation Managers
<p>Treatment should not just look at forensic but also general well-being</p> <p>Help for mental health important.</p> <p>'Support to hold on to'.</p> <p>Sometimes people offend because of poor mental health – not understood</p> <p>Would benefit from 'one to one' work outside of groups and follow up work</p> <p>Groups provide social outlet for meeting people</p> <p>Groups good at addressing general life problems as well as offending issues</p> <p>Good Lives Model</p>	<p>Forensic Cognitive groups are a positive treatment intervention</p> <p>Family would like a group to help understand why their family members have offended and that would be a source of support for each other.</p> <p>Treatment location needs to be accessible for families</p> <p>What Works + Responsivity</p>	<p>Treatment and intervention is the added value of the CFT. Group work is very positive - good feedback from patients and family.</p> <p>Groups provide patients with an opportunity to be reflective and learn from past behaviour. They also offer a form of social interaction. They are specialised (and benefit from that) and demonstrate/ manifest the expertise of the CFT.</p> <p>Community mental health does not have time to invest in groups to the value that CFT can.</p> <p>Psychiatry is often a 'firefighting' approach re intervention</p> <p>Group work would benefit from individual follow up work. There</p>	<p>Needs to be mapping of a patients journey from prison to community, links are important in this regard. Proactive rather than reactionary lead.</p> <p>Needs to be more mapping and step down approach from secure hospital and hospital generally to the community. Structured step down that is professionally managed is an essential requirement</p> <p>People are assessed on what they do in hospital- but is it appropriate for this assessment to be transferred into the community? Otherwise there is a good risk of failing.</p> <p>Treatment depends on the individual and should be</p>

Patient	Family	Professional; Psychiatrists	Professional - CJA and Accommodation Managers
<p>What Works</p> <p>Risk and Responsivity</p>		<p>is a sense of loss for patients when the group finishes. Suggestion of 'proper group psychotherapy'.</p> <p>Perception from patients and family that they 'don't get enough' of CFT.</p> <p>CFT is credible. It is a specialised team with specialised skills that deals with complex cases. Ability to access criminal records, have time and resources to do this.</p> <p>What Works + Responsivity</p>	<p>responsive to their needs. Group dynamics is important in managing difficult personalities. Follow up work for individuals after groups to assist in managing difficult emotions that may arise through group work.</p> <p>Goal orientated approach should be adopted. Looking at what people can achieve, not just about the restrictions.</p> <p>Needs to be high tolerance levels of deviant type behaviour</p> <p>Holistic approach is best. Realism required</p> <p>Professionals need to remind themselves why people have restrictions.</p>

Patient	Family	Professional; Psychiatrists	Professional - CJA and Accommodation Managers
			Nature/nurture divide exists amongst some professionals What Works + Responsivity

3. Treatment and Responsivity

Patient	Family	Professional; Psychiatrists	Professional - CJA and Accommodation Managers
<p>Treatment should always be responsive to an individual's specific needs. Responsivity</p> <p>Everyone should be given same standard of help regardless of risk level. Responsivity</p>	<p>Interventions need to be responsive to a person's needs. Forensic are groups responsive to patient's needs – they do this successfully</p> <p>Day care activities criticised (hospital and local) not age responsive, not enough activities. Responsivity</p> <p>Acknowledgement that people with mental health problems can be hard to motivate or engage in treatment – family feel pressure to do this.</p>	<p>Avoid culture of 'patch up' when working with patients.</p> <p>Patients who are difficult should not be avoided or given up on, but rather worked with until 'the penny drops'. Responsivity</p> <p>Accessibility is critical from Psychiatrists view point particularly regarding the interventions and referral process. Referral process could be made more accessible, - too lengthy. Responsivity</p> <p>Where treatment is delivered makes little difference to outcomes, however, though it is best to deliver groups in a location reasonably accessible to patients. Responsivity</p>	<p>Treatment should be proportional to risk and need level. Responsivity</p>

4. Collaboration and Support

Patient	Family	Professional: Psychiatrists	Professional - CJA and Accommodation Managers
<p>See this as positive i.e. working arrangements between CFT and community teams.</p>	<p>Team working amongst professionals in the Trust could be better.</p> <p>The interface and communication between hospital and the community services could be improved i.e. when someone is being discharged from hospital.</p>	<p>There needs to be co-working between the CFT and community mental health teams with better links between teams. Co-delivering groups would lead to a more holistic approach and ensure less 'silo' working. An added bonus would be increased productivity.</p> <p>Increased understanding from hospital of work CFT required.</p> <p>CFT provides advice on how to work with forensic patients and those who are difficult.</p> <p>More input needed re-education for community mental health teams and other Psychiatrists. Knowledge sharing of best practice.</p>	<p>Good links between Prison, PSNI and CFT</p> <p>Joined up approach to working and circle of care.</p> <p>CFT provides guidance and advice</p> <p>Recognition that CFT is an evolving service.</p> <p>Positive communication between CFT and agencies.</p>

		<p>Different approaches exist within the team because team has developed in an ad hoc manner. Induction training of any new forensic team workers would help to ensure a consistent approach.</p> <p>There is a desire for more face-to-face communication, not just written feedback</p>	
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5. Family Involvement and Support

Patient	Family	Professional - Psychiatrists	Professional - CJA and Accommodation
<p>Patients feel their family have confidence in the treatment provided by CFT for them.</p>	<p>Family advocacy role needs to be enhanced and structurally recognised</p> <p>Peer advocacy to influence choice is required</p> <p>Courses and trained by CFT for families would be helpful</p> <p>Forensic support group required for families</p> <p>Respecting patients' rights but also family rights</p> <p>Balancing security with recovery 'you can't get in to a secure Psychiatric ward but you can get out' What Works + Responsivity</p>	<p>Believe it is important to work with the family and understand the family dynamics and 'set up'.</p> <p>What Works + Responsivity</p>	

6. Psychological Well Being

Patient	Family	Professional: Psychiatrists	Professional - CJA and Accommodation Managers
<p>The Groups provide an important social outlet; this is an opportunity to make friends.</p> <p>Confirms importance of 'Good Lives' Model and relationships, social inclusion in promoting a 'good life'.</p> <p>CFT increases your motivation generally, and especially in relation to addressing mental health and offending behaviour.</p> <p>What works and how it works i.e. motivating a person helps address offending behaviour.</p>	<p>Family members feel that the patient (family member) often has a fear regarding their own mental illness and hides symptoms from professionals</p> <p>There needs to be more of a shared understanding between patient family and professional of difficulties and problems and what constitutes 'health and well-being'</p> <p>Differences between family and professional as to what is reality and perception re mental health</p>	<p>Groups are a positive intervention and useful for managing 'difficult personalities'.</p> <p>What works model</p> <p>Patients would benefit from targeted follow up interventions to assist in managing difficult emotions that may arise as result of group work. Responsivity – being responsive to individual needs</p>	<p>See the benefits of forensic groups for overall well being.</p> <p>What works model</p>

7. Public Perceptions and Awareness

Patient	Family	Professional: Psychiatrists	Professional - CJA and Accommodation Managers
<p>The PSNI need to be aware of the impact of mental illness on offending – so they ‘know you are not wild like’.</p> <p>Good Lives Model: understanding the individual as a whole person</p>	<p>Community stigma towards people with mental health is still present; situation is improving but more needs to be done through public awareness and education</p> <p>Perception that it is easy to ‘spot’ the person with mental health problems. High visibility of their own family member in shopping centres and ability to ‘pick other people out’ who have mental health problems adds to this</p> <p>There needs to be local acceptability and respect of who we are and the mental illness we have. Impact of NI culture and values – positive and negative? Enabling or Frustrating the treatment process? Good Lives Model: understanding the individual as a whole person</p>		<p>Public require education and awareness on forensic mental health. Public safety is important.</p> <p>Has society failed some people? When a person ends up in prison – what message can society take from this?</p> <p>Good Lives Model: understanding the individual as a whole person</p>

8. Living Environment

Patient	Family	Professional: Psychiatrists	Professional - CJA and Accommodation Managers
	<p>Local environment can be protective of people with mental illness.</p> <p>Good Lives Model: understanding the individual as a whole person</p> <p>What works in Northern Ireland and what is the best way of making it work in our local environment</p>		<p>People as far as possible should be facilitated in the community if they can be safely managed.</p> <p>Accommodation not always suited to person's needs.</p> <p>Individuals do better if living in their own environment with the right supports. Environment needs to be the 'best fit' for the individual whether the home or hospital. Seeing the person in their own home is positive. Needs to be more 'supported accommodation' for MDOs.</p> <p>There is a strong perception (mostly public?) that hostels may not be the most appropriate environment for persons with</p>

Patient	Family	Professional: Psychiatrists	Professional - CJA and Accommodation Managers
			severe and enduring mental illness. What Works + Responsivity

9. Professional Characteristics

Patient	Family	Professional: Psychiatrists	Professional - CJA and Accommodation Managers
<p>Having a named key worker is important. Knowing that person is 'only a phone call away'.</p> <p>What Works + Responsivity</p>	<p>Family believe that the ability to exercise the skills of empathy and understanding the specific needs of the patient are important.</p> <p>What Works + Responsivity</p> <p>Bridge building with family members.</p> <p>Creating the right atmosphere to deliver the message of care and ensuring it is accepted.</p> <p>Family do have a fear of professionals and the power they have.</p>	<p>Perception of different approaches adopted amongst CFT practitioners.</p> <p>An assertive approach should be adopted and 'face up' to the challenge of working with difficult patients.</p> <p>CFT practitioners have specialised skills and links with Probation, Police and Prison (CJS). This is an added value of the team in addition to easy access to information such as criminal records etc.</p> <p>What Works + Responsivity</p>	<p>CFT is a targeted specialism provides advice guidance and support to agencies. Knowing one another is important factor to positive working arrangements. Working from a sound evidence base is important.</p> <p>What Works + Responsivity</p>

10. Governance

Patient	Family	Professional: Psychiatrists	Professional - CJA and Accommodation Managers
<p>Patients aware of cutbacks and reduction in funds. For example, one less practitioner in the CFT and absence of a secretary when phoning into the service.</p>	<p>Important to ensure that the primary goal is the service users' needs</p> <p>Resources need to be more focussed and a more integrated approach in the Trust area should be adopted</p> <p>Policy should be flexible to meet changing treatment scenes</p> <p>Families need to be consulted where changes are being proposed that may impact on them or their family member</p>	<p>A 'whole systems approach' needs to be adopted. Approach needs to be 'holistic'. Interface issues between teams need to be addressed as often lack of 'buy in' to CFT from community mental health teams and hospital due to lack of knowledge, education and understanding of forensics.</p> <p>Holistic approach needs to be adopted by services with regard to treatment, structures, teams, activities patients engage in.</p> <p>'Cannot operate in silos'.</p> <p>A big issue exists between the discharges of patients from secure environments to the community. Need for a 'stepped</p>	<p>More resources required to safely manage people in community.</p> <p>Concerns about PBNi adequately monitoring offenders in the community.</p>

Patient	Family	Professional: Psychiatrists	Professional - CJA and Accommodation Managers
		<p>down facility', 'too big a gap to jump', and 'no soft landing'.</p> <p>Pressures within Trust (targets) and outside Trust (risk of public enquiries) have adverse impact on service delivery</p> <p>There is an impact of pressures on service delivery and quality i.e. trying to meet targets with limited resources</p> <p>There is a lack of resources and the case work pressures, gaps in patient monitoring produces increased risk and potential enquiries.</p>	

APPENDIX 12: Consent & Questionnaire- Patient

STUDY TWO: QUESTIONNAIRES

Consent & Questionnaire- Patient



Please read the accompanying information sheet and sign the consent form before filling out the questionnaire.

Please return the questionnaire by **16th January 2012** to:

Carolyn Mitchell

Consultant Forensic Psychologist

Pinewood Villa

St. Luke's Hospital

Loughall Road

Armagh

BT61 7PR

Consent Form

Evaluating the Effectiveness of Community Forensic Mental Health Teams: a Northern Ireland perspective

Name of Researcher: Carolyn Mitchell

Consent Statement:

15. I confirm that I have read and understand the information sheet dated 19th October 2010 version 4 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

Please initial box ☐

16. I understand that my participation is voluntary and that I am free to withdraw at any time.

Please initial box ☐

17. I understand that data collected during the study may be looked at by individuals from the research team at the University of Roehampton, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data.

Please initial box ☐

18. I agree to take part in the above study

Please initial box

☐

I agree to take part in this research, and am aware that I am free to withdraw at any point. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings. I understand that I will be given a copy of this consent form to retain.

Name Name of person taking consent: Carolyn Mitchell

Signature Signature

Date Date

Unique ID Code:

Community Forensic Mental Health Teams: A Northern Ireland Perspective (Patient)

Please fill out this form. The information you give will be **confidential**. This means no one but me will see what you write below. **Please tick the**

box in the table below



Date of Birth		
Are you married?	If Yes, please write in this box if you are married, divorced or currently in a relationship	No
Do you have children?	If Yes, please write in this box the number	No

<p>Please write what your mental health problem is (paranoid schizophrenia, depression, alcohol/drugs etc)</p>	
<p>Please write your offence history (what you got into trouble with Police for)</p>	

Instruction:

The questionnaire below asks you about your attitudes towards the Southern Trust Community Forensic Mental Health Team (CFMHT). Please answer the questions in respect of yourself (person receiving CFMHT services).

For each statement please indicate how strongly you agree or disagree by ticking the box which best matches your view.

Please be honest in your answers as this will help us improve our service.

Please answer all the questions and return in the envelope provided to:






Carolyn Mitchell

Community Forensic Mental Health Team

Pinewood Villa, Longstone Hospital,
Loughall Rd, Armagh. Co. Armagh BT61 7PR





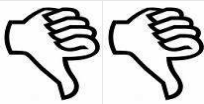
Thank you.

1. Risk Management

1.1 Role of the Key Worker Statements	Strongly Agree 1 	Agree 2 	Neutral 3 	Disagree 4 	Strongly Disagree 5 
1. My forensic key worker plays an important role in my risk management and treatment plan					
2. The gender of my forensic key worker influences my risk management and treatment					
3. The age of my forensic key worker influences my risk management and treatment					
4. The religion of my key worker influences my risk management and treatment					

Please outline in what way (s) you feel the role of your key worker is important:






Do you have any other comments on the various issues raised in this section?

1.2 Risk Management	Strongly Agree 1 	Agree 2 	Neutral 3 	Disagree 4 	Strongly Disagree 5 
Statements					
1. My risk assessment and treatment plan is important					
2. The NI culture and high awareness of equality influences my risk management plan					

How would you improve the current risk management process for forensic patients?

Do you have any other comments on the various issues raised in this section?

2. Treatment Interventions







Statements	Strongly Agree 1 	Agree 2 	Neutral 3 	Disagree 4 	Strongly Disagree 5 
1. Patient participation in forensic therapeutic groups is important for an individual's mental health, social well-being and risk of offending					
2. Having a purposeful and fulfilled life plays an important role in preventing a person from re-offending					
3. The 'troubles' in Northern Ireland has had a negative impact on patient rehabilitation					
4. A support group for families of patients with forensic mental health needs would be beneficial					
5. In treatment there should be equal focus on offending needs, mental health needs and the development of life skills					
6. There should be a stepped down facility between secure environment and community living for forensic patients					

In your opinion what do you think a treatment plan for someone with forensic mental health needs should have?

What would a step down facility for forensic patients in Northern Ireland look like?

Do you have any other comments on the various issues raised in this section?

3. Treatment and Responsivity






Statements	Strongly Agree 1 	Agree 2 	Neutral 3 	Disagree 4 	Strongly Disagree 5  
1. My family plays an important role in motivating and encouraging me to engage in treatment					
2. Professionals (staff) have an important role to play in motivating and encouraging me to engage in treatment					

In what ways can professionals help motivate you to engage in treatment?

In what ways can your family help motivate you to engage in treatment?

Do you have any other comments on the various issues raised in this section?

4. Collaboration and Support






Statements	Strongly Agree 1 	Agree 2 	Neutral 3 	Disagree 4 	Strongly Disagree 5 
1. Services between the hospital and the community for forensic patients need to be improved upon. For example if discharged from hospital into the community					
2. The forensic team need to increase awareness of the service and what they do					
3. Working relationships between the forensic team and other teams (community mental health teams, hospital etc.) could be improved upon					

What are the positives in the working relationships between the community forensic team and other teams?

Could this relationship be improved upon?

Do you have any other comments on the various issues raised in this section?





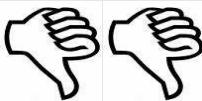
5. Family Involvement and Support

Statements	Strongly Agree 1 	Agree 2 	Neutral 3 	Disagree 4 	Strongly Disagree 5 
1. My family plays an important role in my risk management and treatment					
2. More support should be offered to the family of patients with forensic needs					

How could professionals assist your family with your risk management and treatment?

Do you have any other comments on the various issues raised in this section?






6. Psychological Well Being

Statements	Strongly Agree 1 	Agree 2 	Neutral 3 	Disagree 4 	Strongly Disagree 5 
1. Social outlets and relationships help promote an offence free life					
2. Persons with and forensic mental health needs are fearful of their illness					
3. Families of people with forensic mental health needs are fearful of the impact on the family					

What kind of fears if any do you have about having forensic mental health needs?

Do you have any other comments on the various issues raised in this section?

7. Public Perception and Awareness






Statements	Strongly Agree 1 	Agree 2 	Neutral 3 	Disagree 4 	Strongly Disagree 5 
1. People who have forensic mental health needs are looked upon differently by others					
2. Public perception and awareness of mental illness and offending behaviour has a negative impact on my treatment and recovery					
3. The public need to be educated more on mental illness and offending behaviour					
4. The religious and cultural divide in Northern Ireland has a negative impact on recovery and rehabilitation of people with forensic mental health needs					
5. There is still stigma attached to mental illness and offending behaviour					

Do you feel people look at you differently because you have mental health needs and a forensic history? If yes, how do you feel this could be overcome?

How, if at all, has the religious and cultural divide in Northern Ireland impacted on your mental health and getting well?

Do you have any other comments on the various issues raised in this section?






8. Living Environment

Statements	Strongly Agree 1 	Agree 2 	Neutral 3 	Disagree 4 	Strongly Disagree 5 
1. People with forensic mental health needs require a living environment that is specific to their needs					
2. People with forensic mental health needs require additional supports in their living environment					
3. In Northern Ireland there is a negative bias towards locating people with forensic mental health needs in supported living environments					

In your opinion what should the living environment for people with forensic mental health needs look like? What extra supports do people with forensic needs require from their living environment?

Do you have any other comments on the various issues raised in this section?

9. Professional Characteristics






Statements	Strongly Agree 1 	Agree 2 	Neutral 3 	Disagree 4 	Strongly Disagree 5 
1. Gender, cultural background and religion influence the working relationship between patient and professional					
2. Personal qualities such as empathy, rapport and trust are as important as technical skills (knowledge about mental health) when working with someone with forensic mental health needs					

What are the most important characteristics and skills for a professional to have when working with someone who has forensic mental health needs?

What are the key factors in building good relationships between the patient, family and professional? What are the stumbling blocks to these?

Do you have any other comments on the various issues raised in this section?

10. Governance

Statements	Strongly Agree 1 	Agree 2 	Neutral 3 	Disagree 4 	Strongly Disagree 5 
1. Organisational constraints impact on the rehabilitation of people with forensic mental health needs					
2. Improvements need to be made to forensic services ensure a whole systems approach so that a 'silo mentality' (working alone) when working with patients is avoided					

If you feel organisational pressures impact negatively on services provided for people with forensic mental health needs please outline below how this happens and the steps that should be taken to avoid this?

Do you have any other comments on the various issues raised in this section?

Thank you for taking the time to complete this questionnaire.

APPENDIX 13: Consent & Questionnaire- Family

Study Two Questionnaires

Consent & Questionnaire- Family



Unique ID Code:

Community Forensic Mental Health Teams: A Northern Ireland Perspective (Family)

Background Information

Please fill out the background information below. This will help inform the study. This information will be held **confidentially** and is for data collection purposes.

Male ☐ **Female** ☐

Relationship to patient receiving CFMH service e.g. mother, father, sister, brother, friend etc.

Please read the accompanying information sheet and sign the consent form before filling out the questionnaire.

Consent Form

Evaluating the Effectiveness of Community Forensic Mental Health Teams: a Northern Ireland perspective

Name of Researcher: Carolyn Mitchell

Consent Statement:

19. I confirm that I have read and understand the information sheet dated 19th October 2010 version 4 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

Please initial box ☐

20. I understand that my participation is voluntary and that I am free to withdraw at any time.

Please initial box ☐

21. I understand that data collected during the study may be looked at by individuals from the research team at the University of Roehampton, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data.

Please initial box ☐

22. I agree to take part in the above study

Please initial box ☐

I agree to take part in this research, and am aware that I am free to withdraw at any point. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings. I understand that I will be given a copy of this consent form to retain.

Name Name of person taking consent: Carolyn Mitchell

Signature Signature

Date

Instructions:

The questionnaire below asks you about your attitudes towards the Southern Trust Community Forensic Mental Health Team (CFMHT).

Please answer the questions in respect of yourself and your family member (person receiving CFMHT services).

For each statement please indicate how strongly you agree or disagree by ticking the box which best matches your view.

Please be honest in your answers as this will help us improve our service.

Please answer all the questions and return in the envelope provided to:

Carolyn Mitchell

Consultant Forensic Psychologist

Pinewood Villa, St. Luke's Hospital

Loughall Road, Armagh, BT61 7PR

Thank you.

1. Risk Management

1.1 Role of the Key Worker	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Statements	1	2	3	4	5
1. The role of a key worker is important in the development and implementation of a forensic patient's risk management and treatment plan					
2. The gender of the key worker influences how the risk management and treatment of the forensic patient is undertaken					
3. The age of the key worker influences how the risk management and treatment of the forensic patient is undertaken					
4. The religion of the key worker influences how the risk management and treatment of the forensic patient is undertaken					

Please outline in what way (s) you feel the role of the key worker is important:

Do you have any other comments on the various issues raised in this section?

1.2 Risk Management	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Statements	1	2	3	4	5
1. A good risk assessment and treatment plan is critical to a forensic patient's risk management					
2. 'Playing safe' and being 'risk adverse' when writing risk assessments has a negative impact on a forensic patients' risk management and treatment plan					
3. The NI culture and high awareness of equality reinforces the 'play safe' culture in risk assessment and management					

How would you improve the current risk management process for forensic patients?

Do you have any other comments on the various issues raised in this section?

2. Treatment Interventions

Statements	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
	1	2	3	4	5
1. Patient participation in forensic therapeutic groups is important for an individual's mental health, social well being and risk of offending					
2. Having a purposeful and fulfilled life plays an important role in preventing a person from re-offending					
3. The 'troubles' in Northern Ireland has had a negative impact on patient rehabilitation					
4. A support group for families of patients with forensic mental health needs would be beneficial					
5. In treatment there should be equal focus on offending needs, mental health needs and the development of life skills					
6. There should be a stepped down facility between secure environment and community living for forensic patients					

In your opinion what do you think should be the core components of a treatment plan for someone with forensic mental health needs?

What would be the best approach for a step down facility in Northern Ireland?

Do you have any other comments on the various issues raised in this section?

3. Treatment and Responsivity

Statements	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
	1	2	3	4	5
1. The forensic patient's family plays an important role in motivating and encouraging a person to engage in treatment					
2. Professionals have an important role to play in motivating a person to engage in treatment					

What steps or procedures should be deployed when working with the most difficult/challenging patients/offenders?

What role should professionals play in motivating the patient to engage?

What role does the family play in motivating the patient to engage?

Do you have any other comments on the various issues raised in this section?

4. Collaboration and Support

Statements	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
	1	2	3	4	5
1. Transition services (moving) between the hospital and the community for forensic patients need to be improved upon					
2. The forensic team need to increase awareness of the service and what they do					
3. Relationships between the forensic team and other teams (community mental health teams, hospital, etc.) could be improved upon					

What are the key components to effective team working between the forensic team and other teams in the management of forensic patients? Do you feel this is happening?

How could transition services for forensic patients between hospital and community be improved upon?

Do you have any other comments on the various issues raised in this section?

5. Family Involvement and Support

Statements	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
	1	2	3	4	5
1. The family plays a crucial role in the management of a forensic patient					
2. More support should be offered to the family of patients with forensic needs					

How could the family role in the management of the patient be assisted or enhanced?

Do you have any other comments on the various issues raised in this section?

6. Psychological Well Being

Statements	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
	1	2	3	4	5
1. Social outlets and relationships help promote an offence free life					
2. Persons with a mental illness and forensic history are fearful of their illness					
3. Families of people with a mental illness and forensic history are fearful of the impact on the family					

What kind of fears do you feel people with a mental illness and forensic history have?

Do family members experience the same kind of fears or different, if so what are these?

Do you have any other comments on the various issues raised in this section?

7. Public Perception and Awareness

Statements	Strongly Agree 1	Agree 2	Neutral 3	Disagree 4	Strongly Disagree 5
1. People who have a mental illness and forensic history are perceived differently by others					
2. Public perception and awareness of mental illness and offending behaviour has a negative impact on treatment and recovery					
3. The public need to be educated more on mental illness and offending behaviour					
4. The religious and cultural divide in Northern Ireland has had a negative impact on recovery and rehabilitation of people with a mental illness					
5. There is still stigma attached to mental illness and offending behaviour					

What role if any does society play in the rehabilitation of offenders? What can be done to educate the public?

How if at all has the religious and cultural divide in Northern Ireland impacted on the recovery of people with mental illness and offending behaviour?

Do you have any other comments on the various issues raised in this section?

8. Living Environment

Statements	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
	1	2	3	4	5
1. People with forensic mental health needs require a living environment that is specific to their needs					
2. People with forensic mental health needs require additional supports in their living environment					
3. In Northern Ireland there is a negative bias towards locating people with forensic mental health needs in supported living environments					

In your opinion what is the 'best fit' in terms of living environment for people with forensic mental health needs?

What additional supports do people with forensic needs require from their living environment?

Do you have any other comments on the various issues raised in this section?

9. Professional Characteristics

Statements	Strongly Agree 1	Agree 2	Neutral 3	Disagree 4	Strongly Disagree 5
1. Gender, cultural background and religion influence the working relationship between patient and professional					
2. Personal qualities such as empathy, rapport and trust are as important as technical skills when working with someone with forensic mental health needs					

What are the most important characteristics and skills for a professional to have when working with someone who has forensic mental health needs?

What are the key factors in building productive relationships between the patient, family and professional? What are the stumbling blocks to these?

Do you have any other comments on the various issues raised in this section?

10. Governance

Statements	Strongly Agree 1	Agree 2	Neutral 3	Disagree 4	Strongly Disagree 5
1. Organisational constraints impede on the rehabilitation of people with forensic mental health needs					
2. Improvements need to be made to forensic services ensure a whole systems approach so that a 'silo mentality' (working alone) when working with patients is avoided					

If you feel organisational pressures impede on services provided for people with forensic mental health needs please outline below how this happens and the steps that should be taken to avoid this?

Do you have any other comments on the various issues raised in this section?

Thank you for taking the time to complete this questionnaire.

APPENDIX 14: Consent & Questionnaire- Professional

Study Two Questionnaires

Consent & Questionnaire- Professional



Please sign the consent form before filling out the questionnaire.

Please return the questionnaire by **31st January 2012** to:

Carolyn Mitchell

Consultant Forensic Psychologist

Pinewood Villa, St. Luke's Hospital

Loughall Road

Armagh

BT61 7PR

If you have any questions regarding the questionnaire please feel free to contact me on: 02837412542.

Consent Form

Evaluating the Effectiveness of Community Forensic Mental Health Teams: a Northern Ireland perspective

Name of Researcher: Carolyn Mitchell

Consent Statement:

23. I confirm that I have read and understand the information sheet dated 19th October 2010 version 4 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

Please initial box

☐

24. I understand that my participation is voluntary and that I am free to withdraw at any time.

Please initial box

☐

25. I understand that data collected during the study may be looked at by individuals from the research team at the University of Roehampton, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data.

Please initial box

☐

26. I agree to take part in the above study

Please initial box

☐

I agree to take part in this research, and am aware that I am free to withdraw at any point. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings. I understand that I will be given a copy of this consent form to retain.

Name Name of person taking consent: Carolyn Mitchell

Signature Signature

Date Date

Unique ID Code:

Community Forensic Mental Health Teams: A Northern Ireland Perspective (Professionals)

Background Information

Please fill out the background information below. This will help inform the study. This information will be held confidentially and is for data collection purposes.

Male ☐ **Female** ☐

Profession/Job:

Organisation you work for e.g. Southern Trust, PBNI, PSNI, NIPS, and Hostel, etc.:

Instructions: The questionnaire below asks you about your attitude and opinions towards the Southern Trust Community Forensic Mental Health Team (CFMHT) and services the team is involved in. For each statement please indicate how strongly you agree or disagree by ticking the box which best matches your view.

Please answer all the questions and return in envelope provided.

1. Risk Management

1.1 Role of the Key Worker	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Statements	1	2	3	4	5
1. The role of a key worker is important in the development and implementation of a forensic patient's risk management and treatment plan					
2. The gender of the key worker influences how the risk management and treatment of the forensic patient is undertaken					
3. The age of the key worker influences how the risk management and treatment of the forensic patient is undertaken					
4. The religion and/or the cultural background of the key worker influences how the risk management and treatment of the forensic patient is undertaken					

Please outline in what way (s) you feel the role of the key worker is important:

Do you have any other comments on the various issues raised in this section?

1.2 Risk Management	Strongly Agree 1	Agree 2	Neutral 3	Disagree 4	Strongly Disagree 5
Statements					
1. A good risk assessment and treatment plan is critical to a forensic patient's risk management					
2. 'Playing safe' and being 'risk adverse' when writing risk assessments has a negative impact on a forensic patients' risk management and treatment plan					
3. The NI culture, high awareness of equality (legislation etc) reinforces the 'play safe' culture in risk assessment and management					

How would you improve the current risk assessment process for forensic patients?

Do you have any other comments on the various issues raised in this section?

2. Treatment Interventions

Statements	Strongly Agree 1	Agree 2	Neutral 3	Disagree 4	Strongly Disagree 5
1. Patient participation in forensic therapeutic groups is important for an individual's mental health, social wellbeing and risk of offending					
2. Having a purposeful and fulfilled life plays an important role in preventing a person from re-offending					
3. The 'troubles' in Northern Ireland has had a negative impact on patient rehabilitation					
4. A support group for families of patients with forensic mental health needs would be beneficial					
5. In treatment there should be equal focus on offending needs, mental health needs and the development of life skills					
6. There should be a 'stepped down' facility between secure environment and community living for forensic patients					

In your opinion what do you think should be the core components of a treatment plan for someone with forensic mental health needs?

What would be the best approach for a 'step down' facility in Northern Ireland?

Do you have any other comments on the various issues raised in this section?

3. Treatment and Responsivity

Statements	Strongly Agree 1	Agree 2	Neutral 3	Disagree 4	Strongly Disagree 5
1. The forensic patient's family plays an important role in motivating and encouraging a person to engage in treatment					
2. Professionals have an important role to play in motivating a person to engage in treatment					

What steps or procedures should be deployed when working with the most difficult patients/offenders?

What role should professionals play in motivating the most difficult offender to engage?

Do you have any other comments on the various issues raised in this section?

4. Collaboration and Support

Statements	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
	1	2	3	4	5
1. Transition services between the hospital and the community for forensic patients need to be improved upon					
2. The forensic team need to increase awareness of the service and what they do					
3. Relationships between the forensic team and other teams could be improved upon					

What are the key components to effective team working between the forensic team and other teams in the management of forensic patients? Do you feel this is happening? If not, why?

How could transition services for forensic patients between hospital and community be improved upon?

Do you have any other comments on the various issues raised in this section?

5. Family Involvement and Support

Statements	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
	1	2	3	4	5
1. The family plays a crucial role in the management of a forensic patient					
2. More support should be offered to the family of patients with forensic needs					

How could the family role in the management of the patient be assisted or enhanced? What support could be offered

Do you have any other comments on the various issues raised in this section?

6. Psychological Well Being

Statements	Strongly Agree 1	Agree 2	Neutral 3	Disagree 4	Strongly Disagree 5
1. Social outlets and relationships help promote an offence free life					
2. Persons with a mental illness and forensic history are fearful of their illness					
3. Families of people with a mental illness and forensic history are fearful of the impact on the family					

What kind of fears do you feel people with a mental illness and forensic history have?

Do family members experience the same kind of fears or different, if so what are these?

Do you have any other comments on the various issues raised in this section?

7. Public Perception and Awareness

Statements	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
	1	2	3	4	5
1. People who have a mental illness and forensic history are perceived differently by others					
2. Public perception and awareness of mental illness and offending behaviour has a negative impact on treatment and recovery					
3. The public need to be educated more on mental illness and offending behaviour					
4. The religious or cultural divide in Northern Ireland has had a negative impact on recovery and rehabilitation of people with a mental illness					
5. There is still stigma attached to mental illness and offending behaviour					

What role if any does society play in the rehabilitation of offenders? How could this be improved?

How if at all has the religious and cultural divide in Northern Ireland impacted on the recovery of people with mental illness and offending behaviour?

Do you have any other comments on the various issues raised in this section?

8. Living Environment

Statements	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
	1	2	3	4	5
1. People with forensic mental health needs require a living environment that is specific to their needs					
2. People with forensic mental health needs require additional support in their living environment					
3. In Northern Ireland there is a negative bias towards locating people with forensic mental health needs in supported living environments					

In your opinion what is the 'best fit' in terms of living environment for people with forensic mental health needs? What additional supports do people with forensic needs require from their living environment?

Do you have any other comments on the various issues raised in this section?

9. Professional Characteristics

Statements	Strongly Agree 1	Agree 2	Neutral 3	Disagree 4	Strongly Disagree 5
1. Gender influences the working relationship between patient and professional					
2. Cultural background influences the working relationship between patient and professional					
3. Religion influences the working relationship between the patient and professional					
4. Personal qualities such as empathy, rapport and trust are as important as technical skills when working with someone with forensic mental health needs					

What are the most important characteristics and skills for a professional to have when working effectively with someone who has forensic mental health needs?

What are the key factors in building productive relationships between the patient, family and the professional? What are the stumbling blocks to these?

Do you have any other comments on the various issues raised in this section?

10. Governance

Statements	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
	1	2	3	4	5
1. Organisational constraints (resources, policies) impede on the rehabilitation of offenders					
2. Improvements need to be made to forensic services ensure a whole systems approach so that a 'silo mentality' when working with patients is avoided					

If you feel organisational pressures impede on services provided for people with forensic mental health needs please outline below how this happens and the steps that should be taken to avoid this?

Do you have any other comments on the various issues raised in this section?

Thank you for taking the time to complete this questionnaire

Please return To: Carolyn Mitchell, Pinewood Villa, St. Luke's Hospital, Loughall Rd, Armagh

APPENDIX 15: Questionnaire Data Codes

Study Two - Questionnaires

Group

Patient	1
Family	2
Professional	3

Gender

Male	1
Female	0

Diagnosis

Schizophrenia	1
Personality Disorder	2
Psychosis	3
Alcohol, Drugs...	4
Depression	5
None	6

Offence Type

Sexual	1
Violent	2
Drugs, Alcohol...	3

Professional Group

Nurse	1
Psychiatrist	2
Social worker	3
Probation Officer	4
Police Officer	5
Psychologist	6
Not relevant	7

No Information

No answer given	99
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APPENDIX 16: Questionnaire Codes and Data Areas for SPSS

Study two Questionnaires

Column	Codes	Description
1		Group
2		Age
3		Gender
4		Diagnosis
5		Offence Type
6		Professional type

1- Risk Management (RM)

Column	Codes	Description
7	RM1	Role of Key worker
8	RM2	Gender of Key Worker
9	RM3	Age of key worker
10	RM4	Religion of key worker
11	RM5	Treatment Plan & Risk Assessment
12	RM6	Risk Adverse has negative impact
13	RM7	NI Culture negative

2- Treatment Intervention (TI)

Column	Codes	Description
14	TI1	Forensic Groups
15	TI2	Purpose & Fulfilment
16	TI3	Troubles NI
17	TI4	Support group for families
18	TI5	Equal focus : Good Lives model
19	TI6	Stepped down facility

3- Treatment Responsivity (TR)

Column	Codes	Description
20	TR1	Role of family important
21	TR2	Role of professionals important

4- Collaboration and Support (CS)

Column	Codes	Description
22	CS1	Hospital & community services
23	CS2	CFMHT need awareness
24	CS3	Relationships CFT and others

5- Family Involvement Support (FIS)

Column	Codes	Description
25	FIS1	Role in Risk Management and Treatment
26	FIS2	More support for family

6- Psychological Well Being (PWB)

Column	Codes	Description
27	PWB1	Social outlets/relationships
28	PWB2	Fear of illness
29	PWB3	Impact on family

7- Public Perception & Awareness (PPA)

Column	Codes	Description
30	PPA1	People with mental illness looked upon differently
31	PPA2	Negative impact- treatment & Recovery
32	PPA3	More Public education
33	PPA4	NI Culture negative impact
34	PPA5	Stigma re mental illness and offending

8- Living Environment (LE)

Column	Codes	Description
35	LE1	Specific to needs
36	LE2	Additional Supports
37	LE3	NI Culture negative impact

9- Professional Characteristics (PC)

Column	Codes	Description
38	PC1	Gender- influences working relationships
39	PC2	Cultural background - influences working relationships
40	PC3	Religion influences working relationship
41	PC4	Personal qualities important as tech skills

10-Governance (GV)

Column	Codes	Description
42	GV1	Organisational constraints impede rehab of offenders
43	GV2	Improvements needed to services - whole systems approach

APPENDIX 17: One way ANOVA

Study Two - Questionnaires

SPSS: One way ANOVA and Multiple Comparison Tables*.
The mean difference is significant at the 0.05 level.

Table 1: One way ANOVA: Risk Management (RM)

		Sum of Squares	df	Mean Square	F	Sig.
RM1 Role of Key Worker	Between Groups	4.543	2	2.272	8.934	.000
	Within Groups	18.562	73	.254		
	Total	23.105	75			
RM2 Gender of Key Worker	Between Groups	4.436	2	2.218	1.785	.175
	Within Groups	90.722	73	1.243		
	Total	95.158	75			
RM3 Age of Key Worker	Between Groups	6.760	2	3.380	3.319	.042
	Within Groups	74.345	73	1.018		
	Total	81.105	75			
RM4 Religion of Key Worker	Between Groups	1.827	2	.914	.890	.415
	Within Groups	74.910	73	1.026		
	Total	76.737	75			
RM5 Treatment plan	Between Groups	2.481	2	1.241	3.950	.023
	Within Groups	22.927	73	.314		
	Total	25.408	75			

RM6 Risk Adverse	Between Groups	5.434	1	5.434	7.218	.010
	Within Groups	35.382	47	.753		
	Total	40.816	48			
RM7 NI Culture	Between Groups	18.321	2	9.161	11.510	.000
	Within Groups	58.100	73	.796		
	Total	76.421	75			

Table 2: Multiple Comparisons Risk Management (RM)

Dependent Variable	(I) group	(J) group	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
RM1 Role of Key Worker	1 Patient	2 Family	.590*	.170	.003	.17	1.01
		3 Professional	.472*	.128	.001	.16	.79
	2 Family	1 Patient	-.590*	.170	.003	-1.01	-.17
		3 Professional	-.118	.163	1.000	-.52	.28
	3Professional	1 Patient	-.472*	.128	.001	-.79	-.16
		2 Family	.118	.163	1.000	-.28	.52
RM2 Gender of Key Worker	1Patient	2 Family	-.202	.376	1.000	-1.12	.72
		3 Professional	.398	.284	.495	-.30	1.09
	2 Family	1 Patient	.202	.376	1.000	-.72	1.12
		3 Professional	.600	.361	.301	-.28	1.48

	3Professional	1 Patient	-.398	.284	.495	-1.09	.30
		2 Family	-.600	.361	.301	-1.48	.28
RM3 Age of Key Worker	1 Patient	2 Family	.014	.341	1.000	-.82	.85
		3 Professional	.602	.257	.066	-.03	1.23
	2 Family	1 Patient	-.014	.341	1.000	-.85	.82
		3 Professional	.588	.327	.228	-.21	1.39
	3Professional	1 Patient	-.602	.257	.066	-1.23	.03
		2 Family	-.588	.327	.228	-1.39	.21
RM4 Religion of key Worker	1 Patient	2 Family	.157	.342	1.000	-.68	.99
		3 Professional	.343	.258	.565	-.29	.97
	2 Family	1 Patient	-.157	.342	1.000	-.99	.68
		3 Professional	.186	.328	1.000	-.62	.99
	3Professional	1 Patient	-.343	.258	.565	-.97	.29
		2 Family	-.186	.328	1.000	-.99	.62
RM5 Treatment Plan and	1 Patient	2 Family	.285	.189	.409	-.18	.75

Risk Assessment		3 Professional	.398*	.143	.020	.05	.75
	2 Family	1 Patient	-.285	.189	.409	-.75	.18
		3 Professional	.113	.181	1.000	-.33	.56
	3Professional	1 Patient	-.398*	.143	.020	-.75	-.05
		2 Family	-.113	.181	1.000	-.56	.33
RM7 NI Culture	1 Patient	2 Family	-.006	.301	1.000	-.74	.73
		3 Professional	.981*	.227	.000	.42	1.54
	2 Family	1 Patient	.006	.301	1.000	-.73	.74
		3 Professional	.987*	.289	.003	.28	1.69
	3Professional	1 Patient	-.981*	.227	.000	-1.54	-.42
		2 Family	-.987*	.289	.003	-1.69	-.28

Table 3: One way ANOVA: Treatment Intervention (TI)

		Sum of Squares	df	Mean Square	F	Sig.
TI1 Groups	Between Groups	.612	2	.306	.480	.621
	Within Groups	46.494	73	.637		
	Total	47.105	75			
TI2 Purpose & Fulfilment	Between Groups	2.685	2	1.343	3.038	.054
	Within Groups	32.262	73	.442		
	Total	34.947	75			
TI3 Troubles NI	Between Groups	3.087	2	1.544	1.644	.200
	Within Groups	68.544	73	.939		
	Total	71.632	75			
TI4 Support Group for families	Between Groups	2.957	2	1.478	2.627	.079
	Within Groups	41.083	73	.563		
	Total	44.039	75			
TI5 Equal Focus on Good Lives Model	Between Groups	.597	2	.298	.592	.556
	Within Groups	36.824	73	.504		
	Total	37.421	75			

TI6	Between Groups	15.232	2	7.616	10.632	.000
Stepped	Within Groups	52.294	73	.716		
Down Facility						

Table 4: Multiple Comparisons Treatment Intervention (T1)

			Mean Difference (I- J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
	(I) group	(J) group					
T11 Forensic Groups	1 Patient	2 Family	.162	.269	1.000	-.50	.82
		3 Professional	.194	.203	1.000	-.30	.69
	2 Family	1 Patient	-.162	.269	1.000	-.82	.50
		3 Professional	.032	.258	1.000	-.60	.66
	3 Profess	1 Patient	-.194	.203	1.000	-.69	.30
		2 Family	-.032	.258	1.000	-.66	.60
T12 Purpose & Fulfilment	1 Patient	2 Family	-.125	.224	1.000	-.68	.42
		3 Professional	-.407	.169	.056	-.82	.01
	2 Family	1 Patient	.125	.224	1.000	-.42	.68
		3 Professional	-.282	.215	.582	-.81	.25
	3Profess	1 Patient	.407	.169	.056	-.01	.82
		2 Family	.282	.215	.582	-.25	.81
T13	1 Patient	2 Family	.080	.327	1.000	-.72	.88

Troubles NI		3 Professional	.426	.247	.265	-.18	1.03
	2 Family	1 Patient	-.080	.327	1.000	-.88	.72
		3 Professional	.346	.314	.820	-.42	1.11
	3 Profess	1 Patient	-.426	.247	.265	-1.03	.18
		2 Family	-.346	.314	.820	-1.11	.42
T14 Support group for families	1 Patient	2 Family	.425	.253	.294	-.20	1.05
		3 Professional	.407	.191	.109	-.06	.88
	2 Family	1 Patient	-.425	.253	.294	-1.05	.20
		3 Professional	-.017	.243	1.000	-.61	.58
	3 Profess	1 Patient	-.407	.191	.109	-.88	.06
T15 Equal focus on Good Lives Model		2 Family	.017	.243	1.000	-.58	.61
	1 Patient	2 Family	-.259	.240	.849	-.85	.33
		3 Professional	-.065	.181	1.000	-.51	.38
	2 Family	1 Patient	.259	.240	.849	-.33	.85
		3 Professional	.194	.230	1.000	-.37	.76
T16 Stepped down facility	3 Profess	1 Patient	.065	.181	1.000	-.38	.51
		2 family	-.194	.230	1.000	-.76	.37
	1 Patient	2 Family	.476	.286	.300	-.22	1.18
		3 Professional	.991*	.215	.000	.46	1.52
	2 Family	1 Patient	-.476	.286	.300	1.18	.22

	3 Professional	.515	.274	.192	-.16	1.19
3 Profess	1 Patient	-.991*	.215	.000	1.52	-.46
	2 Family	-.515	.274	.192	1.19	.16

Table 5: One way ANOVA: Treatment Responsivity (TR)

		Sum of Squares	df	Mean Square	F	Sig.
TR1 Role of Family	Between Groups	5.122	2	2.561	4.015	.022
	Within Groups	46.562	73	.638		
	Total	51.684	75			
TR2 Role of Professionals	Between Groups	2.372	2	1.186	3.036	.054
	Within Groups	28.510	73	.391		
	Total	30.882	75			

Table 6: Multiple Comparisons Treatment Responsivity (TR)

Dependent Variable	(I) group	(J) group	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Upper Bound	Lower Bound
TR1 Role of Family	1 Patient	2 Family	.590	.270	.096	-.07	1.25
		3 Professional	-.139	.203	1.000	-.64	.36
	2 Family	1 Patient	-.590	.270	.096	-1.25	.07
		3 Professional	-.729*	.258	.019	-1.36	-.10
	3 Profess	1 Patient	.139	.203	1.000	-.36	.64
		2 Family	.729*	.258	.019	.10	1.36
TR2 Role of Professionals	1 Patient	2 Family	.100	.211	1.000	-.42	.62
		3 Professional	-.315	.159	.155	-.70	.08
	2 Family	1 Patient	-.100	.211	1.000	-.62	.42
		3 Professional	-.415	.202	.132	-.91	.08
	3 Profess	1 Patient	.315	.159	.155	-.08	.70
		2 Family	.415	.202	.132	-.08	.91

Table 7: One way ANOVA Collaboration and Support (CS)

		Sum of Squares	df	Mean Square	F	Sig.
CS1 Hospital and Community Services	Between Groups	22.454	2	11.227	11.065	.000
	Within Groups	74.072	73	1.015		
	Total	96.526	75			
CS2 Awareness	Between Groups	18.271	2	9.136	11.358	.000
	Within Groups	58.716	73	.804		
	Total	76.987	75			
CS3 Relationships with others	Between Groups	18.257	2	9.128	9.268	.000
	Within Groups	71.901	73	.985		
	Total	90.158	75			

Table 8 Multiple Comparisons Collaboration and Support (CS)

Dependent Variable	(I) group	(J) group	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
CS1 Hospital and Community Services	1 Patient	2 Family	.994*	.340	.014	.16	1.83
		3 Professional	1.176*	.256	.000	.55	1.80
	2 Family	1 Patient	-.994*	.340	.014	-1.83	-.16
		3 Professional	.182	.326	1.000	-.62	.98
	3 Profess	1 Patient	-1.176*	.256	.000	-1.80	-.55
		2 Family	-.182	.326	1.000	-.98	.62
CS2 Awareness	1 Patient	2 Family	.496	.303	.318	-.25	1.24
		3 Professional	1.083*	.228	.000	.52	1.64
	2 Family	1 Patient	-.496	.303	.318	-1.24	.25
		3 Professional	.588	.290	.140	-.12	1.30
	3 Profess	1 Patient	-1.083*	.228	.000	-1.64	-.52
		2 Family	-.588	.290	.140	-1.30	.12

CS3 Relationships with others	1 Patient	2 Family	.875*	.335	.033	.05	1.70
		3 Professional	1.065*	.253	.000	.45	1.68
	2 Family	1 Patient	-.875*	.335	.033	-1.70	-.05
		3 Professional	.190	.321	1.000	-.60	.98
	3 Profess	1 Patient	-1.065*	.253	.000	-1.68	-.45
		2 Family	-.190	.321	1.000	-.98	.60

Table 9: One way ANOVA Family Involvement and Support (FIS)

		Sum of Squares	df	Mean Square	F	Sig.
FIS1 Role in Risk & Treatment	Between Groups	1.661	2	.831	1.331	.270
	Within Groups	45.536	73	.624		
	Total	47.197	75			
FIS2 More support for family	Between Groups	1.761	2	.881	1.022	.365
	Within Groups	62.923	73	.862		
	Total	64.684	75			

Table 10 Multiple Comparisons Family Involvement and Support (FIS)

Dependent Variable	(I) group	(J) group	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
FIS1	1 Patient	2 Family	.205	.267	1.000	-.45	.86
		3 Professional	-.194	.201	1.000	-.69	.30
	2 Family	1 Patient	-.205	.267	1.000	-.86	.45
		3 Professional	-.400	.256	.367	-1.03	.23
	3 Profess	1 Patient	.194	.201	1.000	-.30	.69
		2 Family	.400	.256	.367	-.23	1.03
FIS2	1 Patient	2 Family	.256	.313	1.000	-.51	1.02
		3 Professional	.333	.236	.488	-.25	.91
	2 Family	1 Patient	-.256	.313	1.000	-1.02	.51
		3 Professional	.077	.300	1.000	-.66	.81
	3 Profess	1 Patient	-.333	.236	.488	-.91	.25
		2 Family	-.077	.300	1.000	-.81	.66

Table 11: One way ANOVA Psychological Well Being (PWB)

		Sum of Squares	df	Mean Square	F	Sig.
PWB1 Social Outlets	Between Groups	6.172	2	3.086	5.288	.007
	Within Groups	42.604	73	.584		
	Total	48.776	75			
PWB2 Fear of Illness	Between Groups	13.587	2	6.793	8.319	.001
	Within Groups	59.610	73	.817		
	Total	73.197	75			
PWB3 Impact on Family	Between Groups	1.221	2	.610	.623	.539
	Within Groups	71.556	73	.980		
	Total	72.776	75			

Table 12 Multiple Comparisons Psychological Well Being (PWB)

Dependent Variable	I group	(J) group	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
PWB1 Social Outlets	1 Patient	2 Family	-.288	.258	.805	-.92	.34
		3 Professional	-.630*	.194	.005	-1.11	-.15
	2 Family	1 Patient	.288	.258	.805	-.34	.92
		3 Professional	-.342	.247	.513	-.95	.26
	3 Profess	1 Patient	.630*	.194	.005	.15	1.11
		2 Family	.342	.247	.513	-.26	.95
PWB2 Fear of Illness	1 Patient	2 Family	.724	.305	.061	-.02	1.47
		3 Professional	-.454	.230	.157	-1.02	.11
	2 Family	1 Patient	-.724	.305	.061	-1.47	.02
		3 Professional	-1.177*	.292	.000	-1.89	-.46
	3 Profess	1 Patient	.454	.230	.157	-.11	1.02
		2 Family	1.177*	.292	.000	.46	1.89
PWB3 Impact on Family	1 Patient	2 Family	.333	.334	.966	-.49	1.15
		3 Professional	.222	.252	1.000	-.40	.84
	1 Family	1 Patient	-.333	.334	.966	-1.15	.49

	3 Professional	-.111	.320	1.000	-.90	.67
3 Profess	1 Patient	-.222	.252	1.000	-.84	.40
	2 Family	.111	.320	1.000	-.67	.90

Table 13: One way Anova Public Perception and Awareness (PPA)

		Sum of Squares	df	Mean Square	F	Sig.
PPA1 People with mental illness looked upon differently	Between Groups	3.131	2	1.565	2.541	.086
	Within Groups	44.974	73	.616		
	Total	48.105	75			
PPA2 Negative impact on treatment and recovery	Between Groups	2.593	2	1.297	1.734	.184
	Within Groups	54.604	73	.748		
	Total	57.197	75			
PPA3 More Public Education	Between Groups	.460	2	.230	.335	.717
	Within Groups	50.211	73	.688		
	Total	50.671	75			
PPA4 NI culture Negative Impact	Between Groups	6.633	2	3.316	3.626	.032
	Within Groups	66.775	73	.915		
	Total	73.408	75			

PPA5 Stigma	Between Groups	2.412	2	1.206	1.860	.163
	Within Groups	47.325	73	.648		
	Total	49.737	75			

Table 14 Multiple Comparisons Public Perception and Awareness (PPA)

Dependent Variable	(I) group	(J) group	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
PPA1	1 Patient	2 Family	.342	.265	.603	-.31	.99
		3 Professional	.444	.200	.088	-.05	.93
	2 Family	1 Patient	-.342	.265	.603	-.99	.31
		3 Professional	.103	.254	1.000	-.52	.72
	3 Profess	1 Patient	-.444	.200	.088	-.93	.05
		2 Family	-.103	.254	1.000	-.72	.52
PPA2	1 Patient	2 Family	.288	.292	.983	-.43	1.00
		3 Professional	.407	.220	.205	-.13	.95
	2 Family	1 Patient	-.288	.292	.983	-1.00	.43
		3 Professional	.120	.280	1.000	-.57	.81
	3 Profess	1 Patient	-.407	.220	.205	-.95	.13
		2 Family	-.120	.280	1.000	-.81	.57
PPA3	1 Patient	2 Family	.191	.280	1.00	-.50	.88
		3 Professional	.148	.211	1.000	-.37	.67

PPA4	2 Family	1 Patient	-.191	.280	1.00	-.88	.50
		3 Professional	-.043	.268	1.000	-.70	.61
	3 Profess	1 Patient	-.148	.211	1.00	-.67	.37
		2 Family	.043	.268	1.000	-.61	.70
	1 Patient	2 Family	.003	.323	1.00	-.79	.79
		3 Professional	.593	.243	.052	.00	1.19
	2 Family	1 Patient	-.003	.323	1.00	-.79	.79
		3 Professional	.590	.309	.182	-.17	1.35
	3 Profess	1 Patient	-.593	.243	.052	-1.19	.00
		2 Family	-.590	.309	.182	-1.35	.17
PPA5	1 Patient	2 Family	.308	.272	.784	-.36	.97
		3 Professional	.389	.205	.185	-.11	.89
	2 Family	1 Patient	-.308	.272	.784	-.97	.36
		3 Professional	.081	.261	1.000	-.56	.72
	3 Profess	1 Patient	-.389	.205	.185	-.89	.11
		2 Family	-.081	.261	1.000	-.72	.56

Table 15 One way Anova Living Environment (LE)

		Sum of Squares	df	Mean Square	F	Sig.
LE1 Specific to Needs	Between Groups	.072	2	.036	.045	.956
	Within Groups	58.704	73	.804		
	Total	58.776	75			
LE2 Additional Supports	Between Groups	3.311	2	1.656	2.163	.122
	Within Groups	55.886	73	.766		
	Total	59.197	75			
LE3 NI Culture Neg Impact	Between Groups	.494	2	.247	.320	.727
	Within Groups	56.453	73	.773		
	Total	56.947	75			

Table 16: Multiple Comparisons Living Environment (LE)

Dependent Variable	(I) group	(J) group	Mean Difference (I- J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
LE1 Specific to Needs	1 Patient	2 Family	.063	.303	1.000	-.68	.80
		3 Professional	.065	.228	1.000	-.49	.62
	2 Family	1 Patient	-.063	.303	1.000	-.80	.68
		3 Professional	.002	.290	1.000	-.71	.71
	3 Profess	1 Patient	-.065	.228	1.000	-.62	.49
		2 Family	-.002	.290	1.000	-.71	.71
LE2 Additional Supports	1 Patient	2 Family	.595	.295	.142	-.13	1.32
		3 Professional	.296	.223	.563	-.25	.84
	2 Family	1 Patient	-.595	.295	.142	-1.32	.13
		3 Professional	-.299	.283	.883	-.99	.39
	3 Profess	1 Patient	-.296	.223	.563	-.84	.25
		2 Family	.299	.283	.883	-.39	.99
LE3 NI culture Negative Impact	1 Patient	2 Family	.017	.297	1.000	-.71	.74
		3 Professional	.167	.224	1.000	-.38	.72

	2 Family	1 Patient	-.017	.297	1.000	-.74	.71
		3 Professional	.150	.285	1.000	-.55	.85
3 Profess		1 Patient	-.167	.224	1.000	-.72	.38
		2 Family	-.150	.285	1.000	-.85	.55

Table 17: One way ANOVA Professional Characteristics (PC)

		Sum of Squares	df	Mean Square	F	Sig.
PC1 Gender	Between Groups	26.012	2	13.006	16.603	.000
	Within Groups	57.185	73	.783		
	Total	83.197	75			
PC2 Cultural	Between Groups	41.602	2	20.801	42.659	.000
	Within Groups	35.595	73	.488		
	Total	77.197	75			

Table 18: Multiple Comparisons Professional Characteristics (PC)

Dependent Variable	(I) group	(J) group	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
PC1	1 Patient	2 Family	-.259	.299	1.000	-.99	.47
		3 Professional	1.074*	.225	.000	.52	1.63
	2 Family	1 Patient	.259	.299	1.000	-.47	.99
		3 Professional	1.333*	.286	.000	.63	2.04
	3Profess	1 Patient	-1.074*	.225	.000	-1.63	-.52
		2 Family	-1.333*	.286	.000	-2.04	-.63
PC2	1 Patient	2 Family	.208	.236	1.000	-.37	.79
		3 Professional	-1.407*	.178	.000	-1.84	-.97
	2 Family	1 Patient	-.208	.236	1.000	-.79	.37
		3 Professional	-1.615*	.226	.000	-2.17	-1.06
	3 Profess	1 Patient	1.407*	.178	.000	.97	1.84
		2 Family	1.615*	.226	.000	1.06	2.17

Table 19 : One way ANOVA Governance (GV)

		Sum of Squares	df	Mean Square	F	Sig.
GV1 Organisation Constraints	Between Groups	7.943	2	3.971	4.696	.012
	Within Groups	61.741	73	.846		
	Total	69.684	75			
GV2 Improvements To Services	Between Groups	15.269	2	7.634	7.998	.001
	Within Groups	69.679	73	.955		
	Total	84.947	75			

Table 20: Multiple Comparisons: Governance (GV)

Dependent Variable	(I) group	(J) group	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
GV1 Organisational Constraints	1 Patient	2 Family	-.026	.310	1.000	-.79	.74
		3 Professional	.639*	.234	.024	.07	1.21
	2 Family	1 Patient	.026	.310	1.000	-.74	.79
		3 Professional	.665	.298	.086	-.06	1.39
	3 Profess	1 Patient	-.639*	.234	.024	-1.21	-.07
		2 Family	-.665	.298	.086	-1.39	.06
GV2 Improvements to Services	1 Patient	2 Family	.459	.330	.506	-.35	1.27
		3 Professional	.991*	.249	.000	.38	1.60
	2 Family	1 Patient	-.459	.330	.506	-1.27	.35
		3 Professional	.532	.316	.290	-.24	1.31
	3 Profess	1 Patient	-.991*	.249	.000	-1.60	-.38
		2 Family	-.532	.316	.290	-1.31	.24

**APPENDIX 18: Interview Questions and Related Hypothesis from Questionnaires and
One way ANOVA Results Overview**

STUDY THREE: SEMI - STRUCTURED INTERVIEW QUESTIONS (Q)

1. Risk Management

1. *My forensic key worker plays an important role in my risk management and treatment plan ('RISK-NEED-RESPONSIVITY' Model)*

I predict that all three groups would emphasize the importance of the key worker, particularly the professional group.

Mean scores show all three groups agree with above statement.

Using One way ANOVA: Statistically significant difference between the patient and professional groups and the patient and family groups.

Q) What is it about the role of the key worker in the risk management and treatment plan of a forensic patient that is important?

Probes: What differences if any might there be in how patient, family and professional view the key worker role (in risk management and treatment)?

2. *The gender of my forensic key worker influences my risk management and treatment*

I would be surprised if gender, age or religion was a significant factor in influencing risk management and treatment.

Mean scores show all groups on average reported neutral.

3. *The age of my forensic key worker influences my risk management and treatment*

Means scores highlight that patient and families are of the view that age is not a factor; professionals less likely to agree

One way ANOVA statistics show a significant overall variation between the three groups with the professionals less likely to agree., however, each individual group did not differ significantly from each other

4. *The religion of my key worker influences my risk management and treatment*

Means scores show that patient and families are of the view that religion is not a factor.

One way ANOVA statistics show no significant difference between the three groups.

Q) Why do you think age, gender and religion is of little importance when it comes to the key worker's role in risk management and treatment?

5. *Risk assessment and treatment plan is important ('RISK-NEED-RESPONSIVITY' Model)*

I would predict that professionals would see this as very important and to some extent families and patients. I would want to explore differences between groups.

Mean scores show that all three groups are of the view that risk assessment and treatment plan is important.

One way ANOVA statistics show no significant difference between the three groups

Q) What do you see as important in a patient's risk assessment and treatment plan

6. *Being risk adverse has a negative impact on risk management and patient rehabilitation (not asked of patients)*

No interview q for patient

I would predict that professionals would agree with this statement

Mean scores show that families and professionals agree with this statement.

One way ANOVA statistics highlight a significant difference between the family and professional groups regarding the negative impact of being risk adverse on risk management and rehabilitation.

Q) How does playing safe or being risk adverse impact negatively on a patient's risk management and treatment plan?

What can be done to change this?

Family group Q) Do you think professionals are too cautious when it comes to your risk management and treatment plan? If yes in what way?

7. The NI culture and high awareness of equality influences my risk management plan

This is an unknown and would want to explore the significance if the NI culture for people.

Mean scores show patient and family groups are neutral however professional group see this as more important as a factor.

One way ANOVA statistics highlight a significant difference between the three groups with professional group more likely to agree than the family and patient groups. .

Q) In what way does the NI culture and equality legislation, etc., influence play safe culture?

2. Treatment Interventions

1. Patient participation in forensic therapeutic groups is important for an individual's mental health, social well-being and risk of offending (What works)

I would expect that all three groups would agree that forensic groups are important.

Mean scores show that all three groups agree that this is an important factor.

One way ANOVA statistics show no significant difference between groups.

Q) Why and in what way are forensic therapeutic groups important?

2. Having a purposeful and fulfilled life plays an important role in preventing a person from re-offending (Good Lives Model)

I would expect that all three groups would agree that having a purpose and fulfilled life is important. I would want to draw out specifics of this in interview

Mean scores show that all three groups agree that this is an important factor.

One way ANOVA statistics show no significant difference between the groups.

Q) How is a purposeful and fulfilled life important?

3. The 'troubles' in Northern Ireland has had a negative impact on patient rehabilitation

Again this is an unknown quantity. I would be interested in exploring any difference between the three groups and perhaps amongst the professionals. For example the difference between professionals working in the criminal justice system who may have had more exposure to the troubles compared to health care workers

Mean scores show that all three groups are neutral. Professionals lean from neutral towards agree with this statement.

One way ANOVA statistics show no significant difference between groups.

Q) The general response suggests that all groups have no hard opinion on whether the troubles have had a negative impact on patient rehabilitation. Why?

4. A support group for families of patients with forensic mental health needs would be beneficial (What works Model)

I would expect all three groups to view this as important however would probably be of more significance for the family group. I would want to explore through interview how this could be achieved.

Mean scores show that all three groups agree with this statement.

One way ANOVA Statistics show no statistical difference between the three groups.

Q) What kind of support group for families should be established?

5. In treatment there should be equal focus on offending needs, mental health needs and the development of life skills (Good Lives Model)

I would expect all groups to agree with this, particularly families, and patient group. I would like to explore the extent to which professionals agree with this item.

Mean scores show that all three groups agree with this statement.

One way ANOVA Statistics show no statistical difference between the three groups.

Q) What should treatment look like re offending needs, mental health and life skills?

6. There should be a 'stepped down' facility between secure environment and community living for forensic patients (What works model)

I would only expect the professional group to be interested in this. I would like to explore the extent to which professionals agree with this item and explore what this would look like through interview.

Mean scores show that professionals agree more with this statement compared to the family group, who support it.

Patients tend towards neutral.

One way ANOVA Statistics show a statistical difference between the patient and professional groups.

Q) What should a stepped down facility look like?

3. Treatment Responsivity

1. The forensic patient's family plays an important role in motivating and encouraging a person to engage in treatment ('RISK-NEED-RESPONSIVITY' Model)

I would expect all three groups to agree with this but probably more so the family members. I would want to explore the difference between the three groups.

Mean scores show that all three groups agree with this statement. Family strongly agree with this statement.

One way ANOVA Statistics show there was no overall statistical difference between groups.

Q) The family plays an important role in motivating and encouraging a person to engage in treatment, how can this role be enhanced?

2. Professionals have an important role to play in motivating a person to engage in treatment ('RISK-NEED-RESPONSIVITY' Model)

I would expect all three groups to agree with this. I would want to explore any difference between the three groups.

Mean scores show all three groups agree with this statement.

One way ANOVA show no statistical difference between three groups

Q) The professional plays an important role in motivating and encouraging a person to engage in treatment, how can this role be enhanced?

4. Collaboration and Support

1. Transition services between the hospital and the community for forensic patients need to be improved upon (What works model)

I would expect the professionals to agree with this statement however would predict that patient and family members would not be aware of problems in this area.

Mean scores show patient are neutral to more likely to disagree; the family and professionals generally in agreement.

One way ANOVA show a statistically significant difference between the patient group and the family and professional groups.

Q) How can transition services between the hospital and the community for forensic patients be improved upon

2. The forensic team need to increase awareness of the service and what they do

I would expect the professionals to agree with this statement however would predict that patient and family members would not be aware of problems in this area.

Mean scores show that professionals and family groups agree with this statement. Patients lean towards neutral.

One way ANOVA show a statistically significant difference between patient and professional groups.

Q) How and in what way can the forensic team increase awareness of their service?

3. Relationships between the forensic team and other teams could be improved upon

As above, however it would be interesting to determine whether patient or family group have picked up on any issues in the working relationships between services

Mean scores show that patients have neutral opinion, whereas the family and professional group lean towards agree.

One way ANOVA show a statistically significant difference between the patient and family groups and the professional group.

Q) What steps could be taken to improve relationships between services?

5. Family Involvement and Support

1. The family plays a crucial role in the management of a forensic patient (What works model)

I would expect all three groups to see this as important particularly the family group. I would want to explore how this could be achieved through interview.

The mean scores show that all three groups agree to strongly agree with this statement.

One way ANOVA show no statistical significant difference between all three groups

Q) Why is the role of the family so crucial? How could this be improved?

2. More support should be offered to the family of patients with forensic needs

I would expect all three groups to see this as important particularly the family group. I would want to explore how this could be achieved through interview.

The mean scores show that all three groups agree with this statement.

One way ANOVA show no statistical significant difference between all three groups

Q) What type of additional support could be offered?

6. Psychological Well Being

1. Social outlets and relationships help promote an offence free life (Good Lives, What works Model and 'Risk Need Responsivity')

I would expect all three groups to agree with this item but more so the patient and family groups.

Mean scores show that all three groups agree with this statement, but more so the patient and family groups.

One way ANOVA show a statistically significant difference between the patient group and the family and professional groups

Q) What type of social outlets and relationships help promote an offence free life (are more appropriate?)?

2. Persons with a mental illness and forensic history are fearful of their illness

I would expect the patient and family group to agree more with this statement than the professional group

Mean scores show that the family and the patient agree with this statement, more so the family. The professional group agree to a lesser extent, leaning towards neutral.

One way ANOVA show a statistically significant difference between family group and the patient and professional groups

Q) Persons with a mental illness and forensic history are fearful of their illness, what do you attribute to this and how can it be addressed/managed?

3. Families of people with a mental illness and forensic history are fearful of the impact on the family

I would expect the patient and family group to agree more with this statement than the professional group

Mean scores show that all three groups agree with this statement

One way ANOVA show no statistical significant difference between all three groups

Q) Families of patients with a mental illness and forensic history are fearful of their illness, what do you attribute to this and how can it be addressed/managed?

7. Public Perception and Awareness

1. People who have a mental illness and forensic history are perceived differently by others

I would expect the family and patient groups to agree strongly with this statement. It would be interesting to determine the extent to which professionals agree with this

Mean scores show that all three groups agree with the statement.

One way ANOVA show no statistical significant difference between all three groups

Q) People who have a mental illness and forensic history are perceived differently by others. Why this case and what is can be done differently about it?

2. Public perception and awareness of mental illness and offending behaviour has a negative impact on treatment and recovery

I would expect the family and patient groups to agree strongly with this statement. It would be interesting to determine the extent to which professionals agree with this

Mean scores show that all three groups agree with this statement but less so with the patient group who lean towards neutral.

One way ANOVA show no statistical significant difference between all three groups

Q) Public perception and awareness of mental illness and offending behaviour has a negative impact on treatment and recovery. How can this be addressed?

3. The public need to be educated more on mental illness and offending behaviour

I would expect the family and patient groups to agree strongly with this statement. It would be interesting to determine the extent to which professionals agree with this

Mean scores show that all three groups lean towards strongly agree with this statement.

One way ANOVA show no statistical significant difference between all three groups

Q) How can the public be better educated on mental illness and offending behaviour?
<p>4. <i>The religious or cultural divide in Northern Ireland has had a negative impact on recovery and rehabilitation of people with a mental illness</i></p> <p>Unknown quantity, want to explore the impact of this on all three groups</p> <p>Mean scores show that the patient and family groups are neutral, however the professionals agree with this statement</p> <p>One way ANOVA show a statistically significant difference between groups with the professional group more likely to agree than the other two groups.</p> <p>Q) The religious or cultural divide in Northern Ireland has had a negative impact on recovery and rehabilitation of people with a mental illness. Is this an issue for consideration and if so why and how?</p>
<p>5. <i>There is still stigma attached to mental illness and offending behaviour</i></p> <p>I would expect the family and patient groups to agree strongly with this statement. It would be interesting to determine the extent to which professionals agree with this</p> <p>Mean scores show that all three groups agree with this statement</p>

One way ANOVA show no statistical significant difference between all three groups

Q) What type of stigma is associated most significantly with mental illness and offending behaviour? Ideas for addressing it?

8. Living Environment

1. *People with forensic mental health needs require a living environment that is specific to their needs (What Works, 'RISK-NEED-RESPONSIVITY' Model)*

I would expect all three groups to agree with this statement. This is a very current issue in community forensic services at present, particularly the lack of suitable accommodation for this client group.

Mean scores show that all three groups agree with this statement

One way ANOVA show no statistical significant difference between all three groups

Q) What types of accommodation is most appropriate for people with forensic mental health needs?

2. People with forensic mental health needs require additional support in their living environment

I would expect all three groups to agree with this statement.

Mean scores show that all three groups agree with this statement.

One way ANOVA show no statistical significant difference between all three groups

Q) What additional supports would you suggest is required?

3. In Northern Ireland there is a negative bias towards locating people with forensic mental health needs in supported living environments

This is an unknown quantity and I am not sure how people may respond or want to respond.

Mean scores show that all three groups slightly agree with this statement

One way ANOVA show no statistical significant difference between all three groups

No question necessary

9. Professional Characteristics

1. Gender influences the working relationship between patient and professional

I would expect all three groups to disagree with this statement

Mean scores show that the family and patient groups disagree with the statement. However, the professionals are neutral leaning towards agree.

One way ANOVA show a statistically significant difference with the professional group more likely to agree than the family and patient groups.

Q) seek a comment from the professionals

2. Cultural background influences the working relationship between patient and professional

I would expect all three groups to disagree with this statement

Mean scores show that the family and patients agree with this statement. However the professionals are neutral.

One way ANOVA show a statistically significant difference between the patient and family groups and the professional group.

Q) How and in what way do you think Cultural background may influence the working relationship between the patient and professional?

3. Religion influences the working relationship between the patient and professional

Mean scores not relevant only applied to one group (Professional)

From the numerical data professionals are neutral to disagree.

4. Personal qualities such as empathy, rapport and trust are as important as technical skills when working with someone with forensic mental health needs ('RISK-NEED-RESPONSIVITY' Model)

Mean scores not relevant only applied to one group (Professional). From the numerical data the professionals strongly agree with this statement.

Q) What are the most important personal qualities?

10. Governance

1. Organisational constraints (resources, policies) impede on the rehabilitation of offenders (What works Model)

I would expect professionals to strongly agree with this statement. It is likely that patients and family groups may not be fully aware of the impact of resources on services.

Mean scores show that the professionals agree with this statement and the family and patient groups agree to a lesser extent.

One way ANOVA show no statistical significant difference between all three groups

Q) What are the key constraints? Suggestions for improvement.

2. Improvements need to be made to forensic services ensure a whole systems approach so that a 'silo mentality' when working with patients is avoided

I would expect professionals to strongly agree with this statement. It is likely that patients and family groups may not be fully aware of the impact of silo approach on services.

Mean scores show that the patient group is neutral, the family lean towards agree and the professionals agree.

One way ANOVA show a statistically significant difference; the professional and family groups are more likely to agree than the patient group.

Q) What improvements/suggestions do you have for improvement?